

Invaluable and outsourced: Experiences of private company cleaners working in the public hospital sector in Cape Town.

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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Abstract

In the hospital context, and in research on hospitals, cleaning staff often find themselves on the periphery. This peripheral status is exacerbated when cleaners are employed by private cleaning companies. The intersection of locations these cleaners find themselves in, as cleaners, outsourced support staff and members of the working poor means that their work-life experiences take a particular shape. In an attempt to better understand the work experiences of these staff members, I conducted qualitative interviews with 8 female private company cleaners from four different public hospitals in Cape Town. Alienation, job insecurity, working poverty and emotional labour are used as tools to unpack and understand these experiences. Here I argue that these workers perform work that is far from ancillary or non-essential, work central to the functioning of the hospital space. However, the scope of their work is unappreciated and as a result, so too are the health and safety risks they are exposed to, making them especially vulnerable. This vulnerability is compounded by insecurity and the struggle to make ends meet. Alienating conditions are evident as they are constantly reminded of their status at the bottom of the hospital hierarchy and made to feel insignificant. Engaging with the experiences of these cleaners shows how alienation, insecurity, working poverty and emotional labour manifest in interesting ways. It allows us to see the numerous challenges they face in their working lives, particularly as private company cleaners in a hospital.

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Chapter 1: Introduction

A few years ago South Africa's newspapers were packed with coverage of, and opinions on, striking healthcare workers. The state of South African hospitals and the healthcare system were also topics of interest. The most recent 'hot-button' issue in terms of healthcare is the proposed implementation of a National Health Insurance scheme. From this, what I've come to realise is that healthcare is a persistently important and contentious topic. This is due to both the global prominence of healthcare issues and the central role of healthcare and healthcare workers in South African society.

From the healthcare coverage, and that of the strikes in particular, what drew my attention was the lack of visibility afforded to those who are not necessarily healthcare 'professionals'. In other words, not doctors, nurses or medical students. The only other images and voices that appeared to be present in articles were those of the patients. However, the hospital environment is filled with many other staff members; administrators, managers, clerks, porters, maintenance workers, cleaning, gardening, security and catering staff. This media coverage is indicative of the type of attention, or general lack thereof, paid to those in the hospital space who are not medical professionals, placing them lower in the hospital hierarchy. The media, documentaries, investigative journalism and scholarly research are more often than not focused on the plight and heroism of doctors, nurses and patients.

What I've described above is not unusual. As Munck (1988) points out, the bourgeois press only focuses on low-status workers when they make the news; forcefully making their presence felt. Cleaning workers are an example of this. Cleaners form part of the working poor and we do not often see them; they blend into our landscapes and are often overlooked. They form an invisible and silent mass (Shipler, 2004). As an occupational group, cleaners are particularly invisible and the times in which they become visible are when they are somehow at fault (Ehrenreich, 2001). For me, this sentiment can be extended to general public visibility as hospital cleaners in the South African context are rarely

mentioned outside of discussions around the poor state of hospitals, theft in hospitals and perhaps general strike action. When it comes to the work experiences of hospital cleaners there is a lack of knowledge and understanding. Despite being an important facet of patient health, hospital cleaning is an understudied topic (Salerno *et al.*, 2012; Zuberi, 2011).

The aim of this thesis is to shed light on the work-life experiences of hospital cleaning staff in public sector hospitals, focusing on outsourced hospital cleaners in particular. In line with Zuberi (2011), investigating the experiences of these workers motivates an understanding of the challenges faced by 'low-skilled' workers in the service sector. I see these hospital workers as having an especially unique work-life situation (and corresponding challenges) because of their various 'locations'. First, these workers form part of the working poor, a group caught in an exhausting struggle with poverty; trapped in a zone of low-wage work whereby their living standards cannot improve (Shipler, 2004). In the broader context of the South African labour market their location in the outsourcing chain influences their working poverty and also promotes their job insecurity. Second, the hospital itself is a very distinct workplace, which sets it apart from other workspaces. The health and safety risks here are especially unique. Lastly, the very occupation of cleaner (and one at a private company) comes with another set of dynamics attached. I discuss these locations in more detail in Chapter Two. To me, the intersections of these locations make the experiences of these workers and their work-life particularly trying and stressful.

Another factor that that is relevant is gender. Due to patriarchy under capitalism, the gendered division of labour has meant that providing care in the form of domestic work has been constructed as 'women's work' (Grossman, 2011). Correspondingly, those in domestic work (such as private company cleaners in a hospital) find themselves at the intersection of sex, class and ethnicity, lines along which social inequality is produced (Abrantes, 2012). For example, privatisation, as an increasing labour market trend, has the most negative impact on women (Prizzia, 2005). Service work is very gendered and often reinforces

gender stereotypes and expectations (Hanser, 2012). And low-wage service sector work such as cleaning work is usually done by women (Savage, 2006; Zock, 2005). Even more specifically, women predominantly perform low-status work such as hospital cleaning work (Salerno *et al.*, 2012; Davies, 2010). Even if paid work requires a level of skill and training similar to others, work performed by women of poorer backgrounds will be deemed unskilled (Abrantes, 2012). In light of this, and for reasons of narrowing the scope of the study, the private company cleaners who are the focus of this study are women. The locations identified as important appear to have an even more profound effect on them.

In light of my aim to broaden our knowledge and understanding of the work-life experiences of outsourced hospital cleaning staff, I ask the following questions:

- What are the everyday work activities and interactions of outsourced hospital cleaning staff?
- How does this group's occupation and position in both the outsourcing chain and hospital impact their work-life experiences, activities and interactions?
- What could the effects of these work experiences be, especially in terms of health, safety and physical and psychosocial wellbeing?
- What are the key challenges that characterise these workers' experiences?

The above questions establish a descriptive understanding and then allow me to explore cleaners' experiences through theory. The last of these questions allows me to draw my findings together and to engage with theories and/or concepts which I believe serve as an effective way to frame, and also as useful tools to capture, the experiences of outsourced hospital cleaning staff. In light of their locations, the concepts of alienation and job insecurity seemed to be relevant to the plight of these workers. Also, through the data collection process, the concepts of working poverty and emotional labour proved useful in illuminating their experiences.

According to Grossman (2011: 135), “Accounts of the everyday, of working class life and struggle under capitalism are properly and necessarily accounts of the pain of alienation, oppression and exploitation.” Therefore, I have drawn on Marx’s theory of alienation. It offers the means to explore the lived experiences of workers located in a specific material context. Along with this, in line with Archibald’s (2009b) suggestion, while using Marx’s theory, I also engage with other concepts that deal with more contemporary issues. These relate back to the locations I mentioned before; the overlapping contexts (social structures) in which these individuals find themselves embedded. Since our working lives are always rooted in a broader economic system (Giddens, 2001), these theories and/or concepts seemed relevant. The fact that they can also be used to engage at the level of the individual made them particularly appealing and valuable.

Alienation is identified as an “endemic condition of capitalism”(Novack, 1973: 6). All work under capitalism is alienated (Reiss, 1997) as a result of the manner in which social relations are organised under capitalism (Grant, 2011). Yuill (2011) notes that alienation is located in society’s structures and in the experiences of individuals – the former leading to the latter. Similarly, Twining (1980) suggests that the significance of the concept of alienation is that it is located at the intersection of social-structural conditions and psychological orientation. Therefore, this theory can be used to explore the lived experiences of work under capitalism (Yuill, 2005), through identifying a persistent challenge faced by workers. Also, Marx used alienation from the critical viewpoint of labour (Grant, 2011). In line with this, I hope to use the voices of outsourced hospital cleaning staff to understand their lived work experiences and speak to the issues they confront.

Importantly, the manner in which this project was approached was not completely random. I explored the topic of hospital cleaning staff in my Honours project. This project served to highlight the very particular experiences of outsourced cleaners in this space. It also helped me to identify a number of key areas of interest related to these experiences. This information was useful in making this project more manageable by narrowing my focus and deciding on an

approach to a topic that could be approached from a variety of angles, and utilising a range of theories and concepts. My choice of theory and methodology were guided by my experiences studying these types of workers before.

This project adopts a qualitative research methodology. Punch (2005) notes that the type of questions being posed and the type of data one hopes to generate dictates the choice of method. Here, the qualitative interview method was chosen as it is able to, “provide in-depth information pertaining to participants’ experiences and viewpoints of a particular topic” (Turner, 2010: 754). This suits both the type of questions I ask and the type of data I wish to generate – revolving around experiences. The aims of the project, the data I hoped to generate, as well as time constraints and issues of access shaped the methodological choices in my study. In the end a combination of factors meant that I conducted 11 interviews with eight different private company hospital cleaning staff. Interviews were voice-recorded and transcribed for analysis. Analysis involved applying an analytical hierarchy in order to manage and make sense of the data.

The next part of this thesis (Chapter 2) focuses on the contexts I have identified as an important factor in shaping and understanding the experiences of these workers. The South African labour market, services sector, cleaning industry and hospital contexts will be discussed, with special emphasis on the aspects of these contexts that appear to have the most effect on the workers’ experiences. Chapter 3 is a literature review focused on alienation, job insecurity, working poverty and emotional labour. It also includes research relevant to privatised cleaning workers and cleaners in the hospital context, offering insights into potential health and safety hazards. The methodological and ethical issues of this project will be discussed in Chapter 4. Chapter 5 and 6 are findings and discussion chapters in which answers are given to my research questions and these are related back to the literature. Lastly, Chapter 7 offers a conclusion, the key limitations of this project and my views on what questions should still be explored regarding this topic.

Chapter 2: Setting the Scene

As Giddens (2001: 376) notes, “Work is always embedded in the wider economic system”. Similarly, alienation theory identifies the importance of society’s structures in shaping experience (Yuill, 2011). These must be unpacked in order to adequately engage with and understand the work experiences of these cleaning staff. So too must the other locations I mentioned. These serve as broader contextual influences on work experiences. Referring specifically to hospital cleaning staff, Armstrong, Armstrong and Scott-Dixon (2008) note that context is extremely important in understanding this type of work. This chapter, therefore, looks at three key contexts/locations: the South African labour market, the privatisation of services (specifically in the form of outsourcing) and the hospital.

The South African Labour Market

South Africa remains a country challenged by joblessness and poverty (von Holdt, 2010). Altman (2006: 5) sums up this context as one of “high unemployment, slow employment growth, high earnings inequalities [and] low wages for low skill workers relative to the cost of living”. The levels of poverty in South Africa are astounding. The poverty headcount is 52,3% and this increases to 54,1% when only considering women (Statistics South Africa (StatsSA), 2012). Estimates show that 47% of South Africans live below the poverty line of roughly R459 per month (Bhorat, 2013). In South Africa, income generation and employment largely determine poverty level (Kehler, 2001). South Africa is also extremely unequal. The country’s Gini coefficient is 0.69 (Bhorat, 2013), which means that the majority of the population only scrapes by (Kariem & Mbete, 2012). Income inequality is rife, partly because the demand for higher skilled workers elevates this group’s income disproportionately to that of low-skill workers (Kariem & Mbete, 2012).

According to StatsSA (2013), the country’s unemployment rate is 25,6%. Amongst women, this increases to 28,3%. The unemployment rate is even more

disproportionally spread in terms of race. The unemployment rate for those classified as African is 29,1%, Coloured 25,1% and White just 6%. The Western Cape is one of the provinces with a lower unemployment rate, between 21-25% (Hofmeyr, 2012). As the labour market is flooded with jobseekers, but few jobs are available, the employment absorption rate is 41,3% in South Africa (Hofmeyr, 2012), and 52,1% in the Western Cape (StatsSA, 2013) This negatively affects the bargaining power and vulnerability of employees as they compete for jobs in the context of an infinite reserve labour force (Munck, 1988).

Fields (2000) describes South Africa as having an employment problem. This does not only include the high unemployment rate, but also to the problems of very low hourly wages and long work hours that make an insufficient livelihood. According to the October Household Survey, roughly 3.5 million people in South Africa receive wages below the 'low-earnings line'; the wage necessary to enable an average household to progress out of poverty (Fields, 2000). Roughly 65% of workers in South Africa earn below R2 500 per month. In terms of those workers who earn less than R2 500 per month, 83% are Black African and 12% are Coloured. According to Altman (2006), 75% of all Black African workers and 60% Coloured workers form part of the working poor. Also, in South Africa, low and semi-skilled employees are disproportionately Black (Tregenna, 2009).

In terms of the South African Standard Classification of Occupations (SASCO), cleaners fall under the category of 'elementary occupations' (StatsSA, 2001). This group is described as requiring "knowledge and experience of simple and routine tasks which require the use of hand-held tools and in some cases physical effort. It requires limited personal initiative and judgement. Tasks performed by these workers usually include...cleaning, washing, pressing..." (StatsSA, 2001: 22). By the middle of 2013, 2 967 000 people were employed in this occupation group, up slightly from 2009 (StatsSA, 2013). The Western Cape has seen a decrease of 27 000 in the number of employees in this occupation group over the same time period (StatsSA, 2013).

Overall, South Africa has seen an increase in the share of its employment and gross domestic product (GDP) attributed to the service economy (Tregenna, 2009). In terms of both high and low skill jobs, the service sector has become the main source of growth and employment (Altman, 2006). Services (mainly the public sector, infrastructure, utilities and commercial) dominate the domestic industry, accounting for about 65% of output and employment. This expansion of the service sector has enabled the growth of low skill employment. In this industry, cleaning services are predicted to be one of the fastest growing occupations and sectors for employment (Herod & Aguiar, 2006). These developments are in line with the path of industrial development, which sees a growth in services and the increasing prominence of outsourcing (Altman, 2006; Sverke & Hellgren, 2002).

The Privatisation of Services

Privatisation and Outsourcing

Tregenna (2009) attributes some of the growth in services employment in South Africa to the increased employment of cleaners and their reallocation through outsourcing to the private sector. Privatisation means the contracting out (outsourcing) of services (Zuberi & Ptsashnick, 2011). Outsourcing refers to services previously performed in-house being contracted out externally (Tregenna, 2009). Outsourced companies are classified as specialised service-providers (Tregenna, 2009). There has been an increase in outsourcing from the public to the private sector (Tregenna, 2009; Prizzia, 2005). And, as Prizzia (2005: 65) notes, "Privatisation activities are expanding relatively unchecked into traditionally public sector domains", including the public hospital (Zuberi & Ptsashnick, 2011).

Those who support outsourcing argue that it allows a company to concentrate on its core business, leads to lower prices (mostly in terms of lower labour costs), improves control, monitoring and quality, incentivises managers and workers and increases flexibility, adaptability and responsiveness to change (Davies,

2010; Zuberi & Ptshasnick, 2011). Tregenna (2009) adds that outsourcing is also perceived as a form of risk avoidance for a company as they legally have less responsibility and accountability for the outsourced employee. Also, a commercial relationship between the company and the service provider replaces the employment relationship between company and employee (Tregenna, 2009). The company becomes the client, which gives them more power over the private employee (Tregenna, 2009).

There is concern, however, that privatisation negatively impacts the most vulnerable segments of the workforce, especially women workers (Prizzia, 2005: 65). As Prizzia (2005: 55) notes,

The overwhelming concern over the increasing globalisation of privatisation activities tends to focus narrowly on economic factors for success at the expense of social justice for those most affected. These privatisation activities are characterised by short-term economic gains by private sector interest groups without long-term consideration for the least articulate and most vulnerable groups of the affected...

Privatised workers do the same job as public sector workers, but for lower wages (Zuberi & Ptashnick, 2011), and under worse conditions (Davies, 2010). In the public sector, private contracts are often awarded through competitive tender processes. This ensures a constant pressure to decrease costs (Tregenna, 2009). This has meant a decrease in real wages for low skill workers, affecting Black African workers in particular. This is evidenced by the fact that falls in low skill Black African workers' wages is mainly found in small private sector firms (Altman, 2006).

Understaffing is another problem when cleaning work is contracted out. This generally means an excessive workload for the cleaners on duty (Zuberi & Ptashnick, 2011). According to Armstrong *et al.* (2008), privatisation makes teamwork difficult. Outsourcing leads to a fragmented management structure (Davies, 2010). It encourages the division of the workforce into layers of workers; those employed directly by the company and those employed by

private contractors. This fragmentation of the labour force makes unionisation difficult, which weakens the position of workers (Tregenna, 2009). Pension, health benefits and union coverage are lost to privatised workers (Prizzia, 2005). Decreased job insecurity and increased occupational stress are also related to privatisation (Prizzia, 2005).

Outsourcing in the Hospital Context

Interestingly, privatisation is a growing trend even in 'public' hospitals (Zuberi & Ptashnick, 2011; Zuberi, 2011). Outsourcing takes place in public and private sector hospitals. However, before outsourcing, cleaners in the public sector would have been government employees. This makes a big difference for the cleaner (Erickcek, Houseman & Kalleberg, 2003). As Zuberi (2011: 933) states, "What is unique about the challenges faced by outsourced support workers is that they now work for private companies whose aim is to make profits off of their labour rather than simply to run a hospital as efficiently and effectively as possible."

However, the general perception that cleaning is peripheral to the hospital is what underlies the separation of cleaners from the hospitals' clinical team, and justifies its outsourcing (Davies, 2010). Despite the belief of some that the service division (including cleaning work) of the hospital are there to do the daily tasks needed to ensure that the hospital continues to operate (Garrett, 1973), the general perception is that cleaning is a 'non-core' function in this context.

As high-cost operations (Appelbaum Berg, Frost & Preuss, 2003), hospitals have contracted out cleaning and linen services in order to save on expenses (Digby & Thomson, 2008). Previously, in-house employees cleaned hospitals. The trend nowadays, however, is for cleaning work to be outsourced to specialist cleaning companies (Campbell & Peeters, 2008; Erickcek *et al.*, 2003). According to the Health Systems Trust (HST) (2013), 87% of cleaning services in South African health care facilities are contracted out.

Outsourcing has had a number of negative effects on outsourced and hospital staff as well as on the institutions. As Risse (1999: 685) states, “The logic of financial gain is already threatening to undermine the hospital’s ability to function as a house of healing.” For example, one Cape Town hospital has seen a decline in hygiene and cleanliness in recent years. Outsourcing has played a role in this deterioration (Digby & Thomson, 2008). Understaffing, low levels of pay and poor working conditions are associated with cleaning work in the hospital in general, but more so with outsourced hospital cleaning (Davies, 2010). The cleaning company, not the hospital, legally employs the outsourced cleaner. They receive lower pay as a result (Erickcek *et al.*, 2003). Some of Davies’ (2010) findings also imply that outsourced employees do not feel part of the hospital ‘ward teams’ and are not fully integrated into them.

Despite not being formal hospital employees (Erickcek *et al.*, 2003), outsourced cleaners still have the hospital as their workplace. The nature of the hospital as a space needs to be explored in order to fully grasp its meaning and possible effects.

The Hospital Space

Meaning, Function and Organisation of the ‘Hospital’

A hospital is only a building until you hear the slate hooves of dreams galloping upon its roof. You listen then and know that here is no mere pile of stone and precisely cut timber but an inner space full of pain and relief. Such a place invites mankind to heroism .

(Selzer, as cited in Risse, 1999: 3).

Hospitals are one of society’s most valued spaces; they have a certain status and importance (Risse, 1999), some deemed to be “national assets” (Hartley, 2013: 1). According to Vogel (1989: 243), “Hospitals are among the most complex of modern social institutions. They have assumed responsibility for the care of individuals confronting extreme crises.” Therefore, hospitals serve as, “the main concentration of health resources, professional skills and medical equipment”

(WHO, 1987: 8). Garrett (1973: ix) describes, the hospital is a “house of healing.” Customarily, the hospital is a space focused on individual patients and acute curative care that requires extensive resources, up-to-date techniques and well-trained human resources (WHO, 1987).

Hospitals are spaces that prevent disease, regulate epidemics and contain lifesaving practices and miraculous events (Risse, 1999; Garrett, 1973). Pasteur (as cited in Garrett, 1973: 12) identifies the aim of the hospital as, “to cure sometimes, to alleviate often, to comfort always.” Hospitals, because of their status, are also always under public scrutiny (Risse, 1999). They are critiqued for, amongst other things, costing too much, being impersonal and generating in-house infections (Risse, 1999).

When it comes to health and medical care, the hospital is the key institution for the rich and poor (Granshaw, 1989). The socioeconomic status of the hospital’s patients plays a role in the shaping of the space. The idea of the generic hospital is flawed; it is an abstraction. “In reality, there are only particular hospitals, each with its unique name, patrons and mission, buildings, staff and patients” (Risse, 1999: 4). One characteristic is arguably consistent: public hospitals are persistently busy spaces.

An essential component of the hospital is its staff. As Garrett (1973: 14) describes,

The hospital field is filled with men and women of dedication and devotion... In the face of long hours and less than handsome pay, they continue to serve an increasing patient load with increasingly scarce resources. Without these selfless people, the hospital could not perform its functions.

Risse (1999) notes that the media often focuses on the drama of hospital life: heroism and saving lives. However, when the media or public consider the hospital it is medical staff who are focused on. We often forget about the other staff present (Granshaw, 1989).

Similarly, hospitals are often associated with highly skilled and educated, professional medical staff (Appelbaum *et al.*, 2003). However, these spaces also employ a number of what some label as low-skill, low-wage employees (Appelbaum *et al.*, 2003). The hospital hierarchy has managers and professionals at the top and less skilled workers supporting them (Risse, 1999). The latter, which include cleaners, are not seen as 'critical to care' and are perceived as ancillary (Armstrong *et al.*, 2008). Therefore, domestic services are located at the lower end of hospital work value hierarchies (Abrantes, 2012).

Public Sector Hospitals in the South African Context

South Africa's public hospitals fall under the purview of provincial health departments and are funded largely by taxpayers (Biermann, 2006; von Holdt & Murphy, 2006). There are 394 public hospitals in South Africa (Mapumulo, 2014). These are classified into different types: district (level 1), regional (level 2) and central/tertiary (level 3). District hospitals are open all day, all year round. They also offer 24-hour emergency care. These hospitals can have anywhere between 30 and 200 beds with an operating theatre (Cullinan, 2006). Regional hospitals offer a higher level of care through more specialists (Cullinan, 2006). Due to the inefficiency of district hospitals, these are the most burdened level of hospital (Cullinan, 2006). The most specialised hospital is the central hospital. It offers the most intensive clinical care by expert clinicians (Cullinan, 2006; von Holdt & Murphy, 2006). The public health sector comprises 253 district, 55 regional and 10 tertiary hospitals (HST, 2013).

Studies on South Africa's public hospitals have identified these spaces as dysfunctional and stressed (von Holdt, 2010; von Holdt & Murphy, 2006). Further, von Holdt and Murphy (2006) describe public health outcomes as insufficient, characterising public hospitals as failures in that they are unable to provide patients with basic care. The situation currently is that hospitals in South African cities are struggling to cope with the health care needs of the population (Biermann, 2006). According to the Government, around 84% of the country's population rely on the public health sector (Biermann, 2006). While

Biermann (2006) believes that this sector covers only 54% of the population, regardless, a number of South Africans are dependent on the public sector for health care.

In recent years the services in public hospitals have been deteriorating (Cullinan, 2006), what von Holdt describes as case studies of decline. People do not trust government hospitals and there are many stories of unprofessional or inadequate treatment (Cullinan, 2006). Fokazi's (2013) article discusses one specific incident at a Western Cape hospital. Here it is claimed that a patient was made to wait for 18 hours before he was attended to, that nurses were rude, that the bedside manner of staff was insensitive and that the patient's death was hastened because of the poor level of care. Most recently, the Department of Health's audit of hospitals and clinics showed that only one hospital in the country met all necessary standards (Mapumulo, 2014).

Along with chronic staff shortages and the HIV/AIDS epidemic, Cullinan (2006: 2) also identifies "widespread mismanagement, patient neglect and abuse, appalling standards of care, lack of hygiene, lack of infection control and a lack of accountability to patients" as the challenges facing South African hospitals. Other authors (Biermann, 2006; von Holdt & Murphy, 2006; von Holdt & Maserumule, 2005) identify similar concerns, the consensus being that, "there is no end to the list of frustrations and problems" (von Holdt, 2010: 10). Other 'alarm bells' include low levels of hygiene and infection control, maltreatment of patients, poor overall care levels, generally poor working conditions and theft of hospital property (Cullinan, 2006). In the South African case, hospitals are clearly overwhelmed by the number of health and safety concerns faced by those in the space. Von Holdt and Maserumule (2005) touch on similar challenges facing the public hospital, but also include the issue of lack of discipline. Interestingly, with regard to this, cleaners are perceived as the most ill disciplined staff members.

Summary

The scene that has been set above identifies some of the key factors I believe are likely to influence the experiences of private company cleaning staff working in the public hospital. The hospital space is clearly one in which workers are likely to face challenges in doing their jobs, but also one in which they get caught up in the struggle of providing care in under-resourced settings. In working towards the health of others, the health and safety of workers in the hospital may be compromised. Their work is also heavily influenced by broader trends such as privatisation and outsourcing, which has come to dominate their work arrangements. This has meant that their work is seen as peripheral to the core work of the hospital space, and is likely to have implications for how they are treated. The South African labour market is oversaturated with unemployed job seekers. Workers desperate for employment are less powerful to affect their working conditions and are likely to tolerate poorer working conditions. All of the above impacts the experiences of these workers, but also guides the choice of relevant concepts and theories through which to interpret and understand their work experiences. These will be discussed next.

Chapter 3: Literature Review

This chapter unpacks concepts that I believe are useful in exploring the experiences of these particular workers. In light of the context outlined above, I focus on the concepts of alienation, job insecurity and working poverty. I then elaborate on what has been said about cleaning work and the health and safety concerns of this work in the hospital context. Lastly, emotional labour is discussed as a particularly important psychosocial health concern.

Alienation

Marx, who adopted the term 'alienation' from Hegel, is arguably the most prominent theorist on the topic (Sayers, 2011). There is substantial literature on the theory of alienation, but there is a profound lack of agreement on how to define the concept (Yuill, 2011). When it comes to alienation, two main schools of thought are apparent: one Marxist, focused on the social causes of alienation and the other psychological, looking to study the psychological experiences of workers empirically (Kohn, 1976; Yuill, 2011). Twining (1980) suggests that the significance of alienation is that it is located at the intersection of social-structural conditions and psychological orientation. In line with the views of Twining (1980), Archibald (2009b) and Yuill (2011), I feel that these two approaches to alienation need not be mutually exclusive. For my purposes, what they offer in some form of synthesis is a means to investigate the subjective work experiences of hospital cleaning staff as well as locate these in a material socio-economic context.

Marx on Alienation

Through using the concept of alienation, Marx addresses a common experience in a unique way (Reiss, 1997). A central issue of Marx's theory is the relationship between people and nature, a relationship mediated by labour. Under capitalism, this relationship is mediated in ways that alienate human beings (Grant, 2011). It is through the idea of alienation that Marx attempts to show the effects of

capitalist production on the physical and psychological states of people and on their social processes (Ollman, 1971). The theory concerns the power wielded by class society and its products, the fact that the products of people's hands and minds become oppressive, exploitative and control their lives (Reiss, 1997; Mandel, 1973; Novack, 1973).

For Marx, human nature is unfathomable outside of society (McLellan, 1969). Alienation is a historically created phenomenon, born out of specific historical conditions (Novack, 1973). It stems from particular sociological features of society at a specific point in time, i.e. the arrival of capitalism and its subsequent class exploitation (Crimson & Yuill, 2008). As the economic infrastructure of society determines all other relationships within it (Twining, 1980), alienation should be seen as unavoidable and an "endemic condition of capitalism" caused by the very nature of class society (Nelson & O'Donohue, 2006; Novack, 1973: 6). All work under capitalism is alienated, be it clean or dirty, safe or dangerous, professional or non-professional (Reiss, 1997).

Within capitalism, relationships exist beneath the surface. Beneath the reified appearance of commodities we find human activity that is exploited (Yuill, 2005). Capitalism involves the dispossession of the working class from the means of production and the alienation of wage labour (Novack, 1973). Under capitalism all property is converted into private property. This creates a labour force that only owns its own labour-power. This labour must be sold by the worker so as to survive (Grant, 2011). According to Marx, this has particularly damaging consequences for workers, "separating them from all aspects of their humanity and species being and leading to alienation" (Crimson & Yuill, 2008: 463).

Labour is ontologically necessary for humanity (Gimenez, 1992). Through labour the human world is created and people achieve their humanity (Watson, 2003). So, labour constitutes human's species being (Yuill, 2005), people's fundamental life activity. Swingewood (2000: 31) highlights that Marx himself defined labour as "man's self-confirming essence". It is in this same activity that alienation is

embedded. The arrival of capitalism distorted the exercise of labour through a denial to humans of its self-realising qualities (Yuill, 2005). The conditions under which labour is performed in a capitalist society do not enable people to fulfil their humanity (Watson, 2003). The very productive activity that should be pleasurable, fulfilling and rewarding ultimately becomes the source “of all that is wrong in life” (Yuill, 2005: 132).

Central to any description of Marx’s theory of alienation is his categorisation of the four forms of alienation. Many authors have described this fourfold concept of alienation, which Marx addressed at length in the *Economic and Philosophic Manuscripts* or *Parisian Manuscripts* (1844) (see Ollman, 1971; Mandel, 1973; Watson, 2003; Yuill, 2005 and/or Woodfin & Zarate, 2009). From these accounts we can see that people are alienated in terms of their relation to (1) their productive activity (labour process alienation, self-alienation or self-estrangement), (2) their relation to their product (product alienation), (3) their relation to each other (social alienation or fellow human being alienation) and (4) their relation to their species (species-being alienation). Alienation is fundamentally about separation (Nair & Vohra, 2009; Ollman, 1971; Watson, 2003). Ollman (1971: 133-134) summarises Marx’s four states of separation:

Man is spoken of as being separated from his work (he plays no part in deciding what to do or how to do it) – a break between the individual and his life activity. Man is said to be separated from his own products (he has no control over what he makes or what becomes of it afterwards) – a break between the individual and the material world. He is also said to be separated from his fellow men (competition and class hostility have rendered most forms of cooperation impossible) – a break between man and man.

Let me elaborate on these four forms of alienation. Firstly, the worker is alienated from the act of production. Here Marx (1844) points out three key traits of labour process alienation: work is external to the worker, it is forced and it does not belong to the worker. In work under capitalism, people deny instead of fulfil themselves (Marx, 1844). Labour is also a forced activity, described at various times by Marx as a ‘torment’, a ‘sacrifice of life’ and ‘activity as suffering’ (Fraser & Wilde, 2011; Ollman, 1971). The labour activity is also not under the

control of the worker. Labour is objectified (Grant, 2011) as the worker's manager decides every aspect of the productive activity (del Rio, 2006; Ollman, 1971).

Secondly, due to the fact that the labour process is alienated, the products of labour are alienated (Ollman, 1971). This means that the products of labour do not belong to the worker but to their employer (Fraser & Wilde, 2011). More so, the individual's relation to their product is one of "an alien object exercising power over [them]" (Marx, as cited in Ollman, 1971: 142). As Marx (1844: xxii) states,

the object which labour produces – labour's product – confronts it as something alien, as a power independent of the producer. The product of labour is labour which has been embodied in an object, which has become material: it is the objectification of labour. Labour's realisation is its objectification. Under these economic conditions this realisation of labour appears as loss of realisation for the workers; objectification as loss of the object and bondage to it; appropriation as estrangement, as alienation.

In commenting on product alienation, Ollman (1971: 144) notes that: "The worker's needs, no matter how desperate, do not give him a license to lay hands on what these same hands have produced..." It is only through spending the money that they make from their labour that workers can possess what their labour created (Ollman, 1971).

One consequence of the two forms of alienation identified above is social alienation where people are estranged from one another (Grant, 2011). People turn relations between one another into relations between things. This is referred to as reification: "the transformation of social relations into things, into objects" and occurs because people revert to seeing each other "through the lenses of whatever economic relations they have with them" (Mandel, 1973: 25-26). Labour under capitalism establishes a superstructure of ideas, which twists and manipulates the manner in which people should relate to one another. Capitalism instils in workers the idea that they are in competition with one another (Woodfin & Zarate, 2009). Here Marx is highlighting the process of

dehumanisation that alienation encourages as people are estranged from their shared humanity (Grant, 2011).

Finally, and fundamentally, people are alienated from their species being. This form of alienation is qualitatively different from the previous three as it is not tangible (Ollman, 1971). Human species being is characterised by a desire to be social and sociable and to be creative, doing work that is interesting and useful. This is damaged by the alienating conditions of labour (Reiss, 1997). When relationships between humans, our natural world and others become estranged we are not fulfilling our nature (Woodfin & Zarate, 2009). According to Marx (1844: xxiv), alienated labour turns, “man’s species-being, both nature and his spiritual species-property, into a being alien to him, into a means of his individual existence. It estranges from man his own body, as well as external nature and his spiritual aspect, his human aspect.” Under capitalism, work becomes a means to survive and is not fulfilling in itself; turning species-life into a means for individual life (Marx, 1844).

It is pertinent to draw on another quote from Marx. He states that,

the fact that labour is external to the worker, i.e., it does not belong to his intrinsic nature; that in his work, therefore, he does not affirm himself but denies himself, does not feel content but unhappy, does not develop freely his physical and mental energy but mortifies his body and ruins his mind. The worker therefore only feels himself outside his work, and in his work feels outside himself. He feels at home when he is not working, and when he is working he does not feel at home... External labour, labour in which man alienates himself, is a labour of self-sacrifice, of mortification ...the spontaneous activity of the human imagination, of the human brain and the human heart, operates on the individual independently of him – that is, operates as an alien, divine or diabolical activity – so is the worker’s activity not his spontaneous activity. It belongs to another; it is the loss of his self.

(Marx, 1844: xxiii)

Yuill (2005) suggests that this is Marx’s most concise summary of alienation and its effects. Crinson and Yuill (2008) also utilise this quote to glean that there are clearly physical and psychosocial consequences of alienation. The psychosocial

consequences are “assessed in emotional and existential dimensions” (Crimson & Yuill, 2008; 463-464). It is with this in mind that I briefly explore some of the psychological approaches to alienation.

Another Perspective on Alienation

Understandings of alienation differ. Since Marx, the concept of alienation has been used as a means to discuss a general state of psychosocial malaise (Reiss, 1997). In terms of psychological approaches to alienation, the concept is associated variably with the ideas of powerlessness, meaninglessness, normlessness, social isolation, cultural estrangement and self-estrangement (Kohn, 1976; Seeman, 1983). These have been used in attempts to define and measure alienation (Yuill, 2011). This remains a problematic and ambiguous endeavour, however, as no simple definition for these component ideas exists either (Wilson, 2004). Powerlessness, meaninglessness, isolation and self-estrangement appear to be most relevant here and unpacking their meaning can aid in identifying and engaging with alienating experiences.

Powerlessness refers to the belief or sense that one's own behaviour has little or no influence on outcomes (Kohn, 1976). The idea is that life events cannot be controlled or even influenced by the individual. In terms of work, a lack of control, opportunity for control, autonomy and participation is seen as powerlessness (Wilson, 2004; Watson, 2003). The feeling that personal and social situations cannot be understood is considered under the concept of meaninglessness (Seeman, 1975). For Wilson (2004) this concept refers to an inability to see how one's own work contributes to the greater purpose. Meaningless is accentuated when individuals find their work to be dull, boring, unchallenging and separate from the work of others (Wilson, 2004).

Watson (2003) defines isolation as an individual's inability to relate closely to others at work. Social isolation extends this idea, referring to the individual's lack of relation to their work activity, the social relations of the activity as well as the social community beyond the scope of the work activity (Twining, 1980).

Lastly, self-estrangement is a term attempting to capture the notion of a detachment from self. It exists when workers do not feel that their work is self-fulfilling (Mottaz, 1981). Self-estrangement is associated with feelings of boredom, purposelessness and pointlessness (Kohn, 1976). Occurring when jobs are narrow, unfulfilling and unsatisfying, Wilson (2004) describes self-estrangement as a state where the work process is considered alien to the worker and as independent of their contributions. This also occurs when only a fraction of the worker's skill and intelligence is required to complete the work task (Erikson, 1985; Mottaz, 1981)

Making use of the components of alienation described above involves conceptualising alienation as a subjective experience. However, using alienation theory effectively must start from a materialist base so as to show how social organisation affects human beings (Yuill, 2005). In line with this, Archibald's (2009b) interpretation of Marxist theorising of alienation sees the concept as including both objective powerlessness and subjective thoughts and feelings. In my opinion, taken in light of Marx's theory of alienation, more psychological approaches offer some useful vocabulary for understanding and talking about alienating experiences.

Contemporary Relevance and Application of Alienation

There is little new work on alienation; the concept is overlooked in current literature (Nelson & O'Donohue, 2006). Grant (2011) similarly identifies a lack of contemporary use and application of the concept. However, alienation remains a relevant concept today; the phenomena the concept points to have far from disappeared and the ideas involved are seen as "indispensable for sociological...analysis" (Seeman, 1983: 172). Yuill (2011: 105) argues in fact that, "alienative conditions are possibly more prevalent today...with a subtly rendered alienation theory potentially offering considerable insight into a wide range of subjective experiences and structural conditions." Yuill (2011: 115) goes on to say that,

Indeed, given the current social trends of increasing individualisation, the reconfiguration of the workplace, the deepening commodification of many aspects of life, and increasing inequality, it is perhaps now timely to remember what alienation theory can offer as a means to both describe and explain the emotional, individual and social landscapes of this phase of modernity.

Alienation can be used to shed light on the lived experiences of capitalism, experiences believed to be characterised by physical and emotional pain (Yuill, 2005). It is a useful tool as it enables the articulation of how human suffering and self-estrangement are the result of particular relationships between people, their social structures and nature (Yuill, 2011). Alienation does not have one definitive meaning, but themes of the phenomenon can be identified. Yuill (2011) identifies that individual suffering, personal degradation and social malaise as the intrinsic themes of alienation. Ultimately, alienation refers to a situation that should not be; it involves the experience of a loss of self or relationships is; there is a distortion of something pivotal to being a social and private individual and lastly, the cause of the above can be located in the individual's relationship with wider social and historical processes (Yuill, 2011).

Alienating conditions in the class structure and institutions of society will continue to produce feelings of alienation. These may simply take on new forms (Geyer & Heinz, 1992). For example, today increased competition and employment insecurity will influence feelings of alienation (Archibald, 2009b). In a paper entitled 'Globalization, Downsizing and Insecurity: Do We Need to Upgrade Marx's Theory of Alienation?' Archibald (2009b) finds that current alienation research is consistent with Marxist theorising. Despite the fact that Marx may not have predicted the trends in work and employment we see today, these do not invalidate his original theory of alienation.

Alienating working conditions means that workers are dependent and disempowered (Reiss, 1997). If a worker is unable to control their immediate work activity, unable to develop a sense of purpose, unable to see how their job connects to others and unable to see work as a mode of personal expression,

their work is alienating (Wilson, 2004). For Archibald (2009b), globalisation and competition have increased distrust of owners and managers and job insecurity. This has increased objective powerlessness and subjective alienation as predicting and/or influencing one's employers and fellow workers becomes more difficult. Also, the nature of tasks in modern work settings is alienating particularly task specialisation and lack of control over work activities (Mottaz, 1981). Low-level, low-status service workers and manual-labour employees are the most physically alienated from their work (Archibald, 2009b).

For Marx (1844), alienated labour, is a labour of self-sacrifice, of degradation. As labour is external to the worker, through it they deny instead of affirm themselves. Workers do not feel content and do not develop physically or mentally. Rather, the worker feels unhappy, degrades their body and destroys their mind (Marx, 1844). As Yuill (2005) points out, alienation under capitalism negatively affects the health of workers, physically, mentally and emotionally. Alienating work conditions lead to the destruction of workers' bodies and minds (Ollman, 1971). Disenchantment, stress and poor health are the result (Crimson & Yuill, 2008). Psychologically, Marx identifies decaying will power, mental inflexibility and ignorance as the effects of capitalist labour (Ollman, 1971).

In line with this, the relation of the worker to the act of production is described as "activity as suffering, strength as weakness, begetting as emasculating" (Marx, 1844: xxiii). Alienating labour conditions degrade and depersonalise workers (del Rio, 2006). People are not satisfied by their work and they do not find meaning in it (Reiss, 1997). Workers come to feel powerless, isolated, trapped, dissatisfied, exhausted, depressed or apathetic (Reiss, 1997).

Archibald (2009a: 161) describes the noticeable effects of these features of alienating work:

these [cognitive and emotional withdrawal] often entail lowering one's aspirations for gratification. This is so subsequent deprivation and frustration will be less frequent and painful. A common result of this lowering is regarding others and one's work mainly in 'extrinsic',

'instrumental' or utilitarian terms. ...the other [worker] wants only a job, and works in order to live. Similarly, workers often treat fellow workers merely as competitors.

Under capitalism's alienating working conditions, dehumanisation is a natural result, as profits are believed to be more important than people. This means that competition leads to increasing productivity and pressure on the worker (Reiss, 1997). Alienation results in the worker becoming a commodity. Not any commodity, however, but "the most wretched of commodities; that the wretchedness of the worker is in inverse proportion to the power and magnitude of his production" (Marx, 1844: xxii). For those in power, the rich, labour produces delightful things, palaces, beauty and intelligence. But for the worker it produces deprivation, shacks, deformity, stupidity and cretinism (Marx, 1844).

This estrangement of the labourer in their object can be expressed as,

the more the worker produces, the less he has to consume; the more values he creates, the more valueless, the more unworthy he becomes; the better formed his product, the more deformed becomes the worker; the more civilized his object, the more barbarous becomes the worker; the more powerful labour becomes, the more powerless becomes the worker; the more ingenious labour becomes, the less ingenious becomes the worker and the more he becomes nature's servant.

(Marx, 1844: xxiii)

Alienation extends beyond the workplace. Alienation as a state of being resides in the whole of one's existence (Yuill, 2011; Erikson, 1985). As Novack (1973: 6) states: alienation is a "morbid and acute social sickness" that applies to all, "...city dwellers who feel crushed and benumbed by the weight of a social system in which they have neither significant purpose nor decision-making power". According to Schmitt (1994: 2), "the alienated are deprived of formal rights, such as political participation, and are hence unable to ensure humane working conditions and adequate wages." People as citizens give up a number of individual rights to the state as part of their social contract. The state, however, only represents the interests of those who own private property (Mandel, 1973). People experience a loss of rights to institutions that are hostile towards them

(Mandel, 1973). The oppressed in society, therefore, exemplify experiences of alienation (Schmitt, 1994).

Yuill (2011) argues that the contemporary workplace is much harder and less forgiving than in the 1960s and 70s. The conditions that create alienation are even more apparent today. Features of alienating work conditions in the 21st century are increasing fragmentation, individualisation, and social distress, exacerbated by the loss of many positive social and workplace structures (welfare provision and unionisation) (Yuill, 2011).

I adopt the same approach to alienation as Heinz (as cited in Yuill, 2011: 106) who states that,

alienation should be used as a bridging concept between social conditions and individual responses in specific areas of social life like work, politics or community: 'alienation' focuses sociological interests on the various manifestations of a discrepant or conflicting relationship between individuals and their social and historical living conditions.

Yuill (2011) argues that this understanding of alienation is most useful as it highlights how human experience is mediated by structure and agency. Therefore, alienation is able to capture the distress, misery and suffering of people under capitalism (Yuill, 2011). In utilising a 'consolidated' approach to alienation, Twining (1980) notes that context and socio-structural conditions need to be examined as well as individuals' relationships with these. I have already identified how important I feel the locations of these workers are to understanding their experiences. I make use of alienation in order to explore the working lives of hospital cleaning staff in a particular material socio-economic context.

When using alienation theory, Archibald (2009b) suggests exploring and borrowing from other theories that deal with more current issues. In line with this, and highlighting the contextual factors I deem important, I now elaborate on job insecurity and working poverty.

Job Insecurity

“In most contemporary societies, a job holds the key to social integration, social participation and recognition” (De Witte, 2005: 3). It contributes to individual identity, links people to one another and locates an individual in society (Kalleberg, 2008). Employment is said to satisfy certain needs: earning an income, developing social contacts, being able to structure one’s time and personal and social growth (De Witte, 2005). The nature of the employment situation faced by these workers means that employment does not sufficiently meet any of these needs (De Witte, 2005).

The changing nature of the labour market and work in general means that new issues become relevant to the workforce (Dachapalli & Parumasur, 2012). Precarious employment is characteristic of the destabilising era of neoliberal globalisation (Lambert & Webster, 2010). Increasingly we see a core, secure and stable workforce on the one hand and a peripheral, insecure and outsourced workforce on the other (Zuberi, 2011; Bezuidenhout & Aguiar, 2006). Precarious employment refers to work that is uncertain and unpredictable; work that increases perceived job insecurity (Lambert & Webster, 2010; Kalleberg, 2008). Downsizing, restructuring and organisational change are commonplace. As a result, job insecurity is a significant, persistent social phenomenon and has emerged as one of the most relevant concepts when discussing working life (Dachapalli & Parumasur, 2012; De Witte, 2005; Sverke & Hellgren, 2002).

According to Dachapalli and Parumasur (2012: 33), job insecurity is a form of stress that “involves the experience of a threat, and implies a great deal of uncertainty regarding whether individuals get to keep their jobs in the future”. Job security increases when employees feel that their job or its features are threatened. In terms of job insecurity, the idea of uncertainty is stressed; the concept attempts to capture the constant anticipation and fear of losing one’s job (Cooper & Burke, 2002). This constant concern is actually more distressing than the actual loss of a job is problematic because employees cannot prepare themselves sufficiently for the future (Cooper & Burke, 2002). Feelings of

powerlessness, helplessness and lack of control also increase job insecurity (Dachapalli & Parumasur, 2012; De Witte, 2005; Marmot, 1999).

The multidimensional approach to job insecurity suggests that job insecurity also involves a fear of losing job features such as job stability (van Wyk & Pienaar, 2008). It is also about qualitative insecurity, loss of valued job characteristics or features such as pay, access to resources, status, working hours, job content, responsibility and benefits (Dachapalli & Parumasur, 2012). Job insecurity can also be considered as a violation of the psychological contract on the part of the employer. The psychological contract captures the perceived mutual obligations between employer and employee where the employer exchanges security for employee loyalty (De Witte, 2005).

Job insecurity is a subjective experience based on perceptions and interpretations of work situations; individuals will perceive and react to it differently (van Wyk & Pienaar, 2008; De Witte, 2005; Sverke & Hellgren, 2002). Political, economic and social context are important factors that influence experiences of job insecurity (van Wyk & Pienaar, 2008). A country's level of unemployment and economic situation as well as an individual's labour market position has been correlated with job insecurity (De Witte, 2005). For one, high levels of unemployment increase feelings of job insecurity (Lambert & Webster, 2010; Marmot, 1999). The most influential antecedents of job insecurity are those at the macro level (e.g. unemployment and changes in organisational structure) and positional variables such as occupational level (De Witte, 2005).

In light of the above, manual, low-skilled, ancillary and workers with temporary job contracts are more likely to perceive their job situations as insecure (Armstrong *et al.*, 2008; De Witte, 2005). This is partly because less skilled workers have limited employment alternatives (Sverke & Hellgren, 2002). Also, workers on shorter-term contracts have persistent feelings of insecurity, feel they have to work harder, do not belong to trade unions and are always searching for new jobs (Lambert & Webster, 2010). Likewise, those who believe that they have little likelihood of finding alternative employment and who have

economic responsibility for their families are more likely to experience job insecurity (Sverke & Hellgren, 2002).

The impact of job insecurity has become inevitable (van Wyk & Pienaar, 2008). Job insecurity negatively affects the wellbeing of workers, causes significant psychological distress and decreased life satisfaction (De Witte, 2005; Cooper & Burke, 2002). It has been suggested that job insecurity is an important determinant of a worker's health and safety and that insecurity has detrimental effects on employee safety (Takahashi, Sawada & Araki, 2008; van Wyk & Pienaar, 2008; Probst, 2004). In terms of decreased safety compliance, workplace injuries and accidents become more likely (Dachapalli & Parumasur, 2012).

Numerous other potential consequences of job insecurity are identified. Kalleberg (2008) notes that insecurity has consequences on work experiences and individual stress. Other consequences include reduced organisational commitment, job satisfaction, job involvement, job performance, productivity, work effort and motivation. The mistrust of management and the intention to leave are increased. In terms of the individual, burnout, irritation, anxiety, depression as well as psychosomatic and physical ailments are increased because of job insecurity (Dachapalli & Parumasur, 2012). Persistent job insecurity is believed to worsen these effects (Dachapalli & Parumasur, 2012).

It is believed that the growth of low-wage contingent employment (as is the case for the workers in this study) is resulting in insecurity. Importantly, this is especially the case amongst the working poor (Zuberi, 2011). Working poverty will, therefore, be elaborated on next.

Working Poverty

The working poor are those people who work either full-time or part-time, but remain in poverty and working poor families are ones with incomes below the poverty line (Chilman, 1991). The working poor are caught in an exhausting

struggle where the money they earn does not lift them far enough out of poverty to improve their lives (Shipler, 2004). They are trapped in the zone of low-wage work whereby their living standards cannot improve. Any rise in wages does not match the rise in the cost of living (Chilman, 1991). These families live in conditions of poverty and stress that negatively impact family member's physical, psychological and economic health (Chilman, 1991).

Barbara Ehrenreich (2001) gives a somewhat 'lived experience' account of the working poor in America. What Ehrenreich (2001) finds is that, contrary to the 'American Dream' and ideas that hard work and success are intrinsically linked, for the working poor, the cycle of poverty continues and hard work often only leads to more debt and deeper poverty (Ehrenreich, 2001). Therefore, being a low-wage worker is an experience characterised by hopelessness (Ehrenreich, 2001).

Similarly for Shipler (2004), the American myth is that any individual from the humblest origins can climb to wellbeing. According to Shipler (2004: 5), this myth has value, "It sets a demanding standard, both for the nation and for every resident. The nation has to strive to make itself the fabled land of opportunity; the resident must strive to use that opportunity." We have a similar post-apartheid discourse/ideology/myth. Also, the perception in America (as it is in most countries) is that any job is better than no job. Chilman (1991) disputes this, arguing that this is not the case for those who work full-time and are still not able to move their families out of poverty. The large numbers of working poor people is a contradiction to the idea that work brings with it a level of economic security (Chilman, 1991). In America, the working poor are often especially frustrated as they feel that they are obeying the rules of work and following the 'American Dream' with little, if any, success (Chilman, 1991). Similar discourses around hard work are evident in South Africa with similar results; the working poor get poorer.

There is no clear cause for working poverty. The ingredients of poverty are not universal, but are part financial and part psychological, part personal and part

societal, part past and part present (Shipler, 2004). Chilman (1991) emphasises the more macro causes of working poverty. The working poor are in their position because of “problems in the economy; the changed nature of jobs; political trends and government politics; business practices; defects in urban and rural development; and racism, ethnocentrism and sexism” (Chilman, 1991: 196). Shipler (2004), however, notes that the troubles run strongly along both macro and micro levels, as systematic problems in the structure of political and economic power, and as individual problems in personal and family life (Shipler, 2004). Therefore,

Working poverty is a constellation of difficulties that magnify one another: not just low wages but also low education, not just dead-end jobs but also limited abilities, not just insufficient savings but also unwise spending, not just poor housing but also poor parenting, not just the lack of health insurance but also the lack of healthy households.

(Shipler, 2004: 285)

The nature of the jobs occupied by the working poor provides little status and little chance for advancement. They are usually “physically exhausting, repetitious and stultifying” (Chilman, 1991: 193). Ehrenreich (2001) acknowledges that all the low-wage work she undertook was physically demanding and had the potential to damage a worker physically if performed month after month. Two of the jobs Ehrenreich takes as part of her investigation are cleaning occupations. In terms of her cleaning jobs, proximity and contact with hazardous cleaning agents as well as the moving of heavy furniture and cleaning equipment were some of the physical aspects that impact negatively on the health of the worker. Overall, the physical exhaustion that can be associated with low-wage work is captured in Ehrenreich’s (2001: 60) words, “Don’t stop, don’t think, don’t even pause for an instant, because if you do, you’ll be aware of the weariness taking over your legs, and then it will win”.

Low-wage work is not only physically damaging, but psychologically damaging too (Ehrenreich, 2001). Low wages and the struggle to simply ‘make ends meet’ have negative psychological effects on individuals’ including feelings of

inferiority, inadequacy, depression and frustration (Zuberi, 2011; Chilman, 1991). Managers and impersonal rules constantly remind low-wage workers of their lowly position in the social hierarchy (Ehrenreich, 2001). This bombardment leads to workers accepting their relegated status. Similarly, being treated as untrustworthy, lazy or as a potential thief encourages workers to feel that they are these things (Ehrenreich, 2001). For example, Bezuidenhout and Fakier (2006) note that cleaners are routinely accused of theft. As people depend on those around them for their self-image, Ehrenreich (2001: 115) argues that: "the indignities imposed on so many low-wage workers...are part of what keeps wages low. If you're made to feel unworthy enough, you may come to think that what you're paid is what you are actually worth."

One 'justification' for the low status of domestic-type services is the argument that the job does not require complex thinking or reasoning (Abrantes, 2012). Despite popular believe and labels, no job is really 'unskilled'. According to Ehrenreich (2001), every low-wage occupation requires concentration and a grasp of new terminology, new tools and new skills. On top of this, each occupation is also embedded in a "self-contained social world, with its own personalities, hierarchy, customs and standards" (Ehrenreich, 2001: 106). For example, in terms of standards in order to be a good work colleague one needs to be efficient, but not to the point of making things more difficult for others or raising expectations. Similarly, the perception of workers is that revealing one's true capabilities is problematic as "the more they [management] think you can do, the more they'll use you and abuse you" (Ehrenreich, 2001: 107). This is not to be mistaken for laziness, but an understanding that going above and beyond offers little, if any, reward (Ehrenreich, 2001). The specificities of cleaning work will be discussed next.

Cleaning Work

Cleaning work is vital to society, playing an important part in servicing the social order (Woods & Buckle, 2006). Herod and Aguiar (2006) identify cleaners as essential to the maintenance of sanitary, functional social spaces. Similarly,

Grossman (2011) speaks to the fact that domestic work should be considered an essential public service. In the health care context, cleaning staff are essential to the functioning of hospitals in terms of keeping the hospital open, clean and preventing patients from becoming more ill (Ashforth & Kreiner, 1999). Despite their importance, cleaners are largely invisible workers (Herod & Aguiar, 2006). In the health care setting, despite the fact that they do “critically important jobs” (Zuberi, 2011: 923), hospital cleaning staff are often seen as peripheral to the organisation and its main purpose. As Cohen (2006) notes, cleaners in health services are viewed as both non-professional and non-essential. In light of this and because of the type of work they do, cleaners find themselves at the bottom of the hospital hierarchy and in a vulnerable position within the health care context (Zuberi, 2011). These employees are the most at risk of those in the healthcare workforce (Zuberi, 2011) and are more likely to have both short and long term sickness absence, with exacerbated poor health (Michie *et al.*, 2004).

Professional cleaning is a basic service occupation (Zock, 2005). Forming part of the group of low-paid service sector workers, contract cleaners are defined as “cleaners who work as employees for contract cleaning companies” (Campbell & Peeters, 2008: 27). As discussed above, contract cleaning companies are under increasing pressure to cut labour costs. Also, the cleaning workforce is a relatively vulnerable group. These factors often lead to increased work intensity and attempts to avoid minimum labour standards on the part of cleaning companies (Campbell & Peeters, 2008). According to Campbell and Peeters (2008: 44): “the underlying instability in cleaning jobs leads to constant pressure on wages and working conditions, often expressed in the form of work intensification and lowered standards.” This is likely to worsen the effect of working conditions on cleaning staff. Overall, increased subcontracting, intensification of labour and attacks on unions leads cleaning work to appear to be more like sweatshop labour (Herod & Aguiar, 2006; Erickcek *et al.*, 2003). Abrantes (2012) also notes that domestic labour is often seen as unskilled and even unworthy. This leads to a lack of consideration when it comes to the improvement of the working conditions of these workers (Abrantes, 2012).

The main goals of cleaning are to maintain functionality, appearance, and appropriate hygienic conditions of buildings. This may result in a wide variety of work tasks of the cleaning job. In many settings, the hospital included, cleaners not only perform strictly “cleaning”, but also other (related) activities such as disposing waste or wastewater (Zock, 2005). The main activity of the cleaning job is cleaning surfaces. This includes floors, furniture, sanitary fittings, windows, vehicles, machines and other work equipment. This can be done by dusting, wiping, sweeping, or vacuuming, and is very often done with the aid of cleaning products (Zock, 2005). Cleaners usually conduct mopping, vacuuming and buffing daily (Woods & Buckle, 2006). Lifting equipment or machines and carrying or handling heavy loads are also common tasks (Woods & Buckle, 2006).

Cleaning Work and Physical Wellbeing

Acknowledgement of the health and safety risks to healthcare workers has been slow (Bibby, 1995). Likewise, as is the case in many feminised, low-wage service occupations, there is a lack of recognition as to the real physicality of hospital cleaning work (Zuberi, 2011). A number of the health and safety risks present in hospitals have been identified in Chapter 2. Beyond this, cleaners are involved in labour intensive work, which means a lot of physical strain (Salerno *et al.*, 2012). Lack of on-the-job risk training, standing, long walking, distances, high monotony and increased chances of accidents and disease contraction are some of the organisational constraints faced by cleaners (Salerno *et al.*, 2012; Stinson *et al.*, 2005). For privatised workers specifically, “exhaustion, pain, illness and injury are commonplace” (Stinson *et al.*, 2005:7). Ultimately, the physical health of these workers is negatively affected by their jobs.

Cleaning is one of the most injury-prone occupations (Herod & Aguiar, 2006). Bello, Quinn, Perry and Milton (2009) argue that hospital cleaning workers are likely to be an especially vulnerable group because of the variety of products utilised in hospitals and because of the high frequency of cleaning activities in the space. A number of authors discuss the physical risks of cleaning work (see

Woods & Buckle, 2006; Zock, 2005). The cleaning agents used by cleaners are often corrosive at high concentrations, and irritant at lower concentrations (Zock, 2005; Ehrenreich, 2001). Also, chemical cleaning products are often used in higher concentrations or larger amounts than required (Zock, 2005). Arif *et al.* (2008) Hospital cleaning workers in particular have been found to suffer from negative skin effects and health care workers are at risk of developing occupational asthma as a result of the frequent use of cleaning products (Bello *et al.*, 2009). Stepladders and wet floors increase the risk of accidents. Other types of potential accidents include hospital needle pricks as a result of incorrectly stored waste (Zock, 2005).

Lastly, Messing, Chatigny and Courville (1998) state that compared to those in other occupations, cleaners have poorer health. Compared to other health care workers, cleaners in Quebec hospitals have almost double the number of occupational accidents and illnesses. Lacerations, carpal tunnel syndrome, musculoskeletal problems and back and joint pain are some of their health risks (Messing *et al.*, 1998). Cleaners' health concerns stem from a number of working conditions. These vary across context, but can include lack of training, ineffective communication and management, poor protective gear, poor quality of equipment and high work pressure which means "having to cut corners and frequently violate organisation policy in order to do their jobs" (Arif *et al.*, 2008: 460). Also, cleaners are likely to escape from control such as regulations, health surveillance, and risk prevention (Zock, 2005). These conditions highlight the fact that it is not only physical working conditions that shape the work experience of cleaners or the effects of such work.

Cleaning Work and Psychosocial Wellbeing

Low-wage work such as cleaning is not only physically damaging, but psychologically damaging too (Ehrenreich, 2001). Michie, Wren and Williams (2004) identify sickness absenteeism as a major concern when it comes to workers in the health sector. Interestingly, this type of absence is not solely related to issues of physical health, but also psychosocial factors. Low levels of

control at work increases an employee's health risks (Michie *et al.*, 2004). Employees such as cleaning staff identify their jobs as low in control and support as well as low in the variety and use of skills necessary.

Organisational and psychosocial factors such as time pressures, lack of control over work and breaks as well as high workload increases cleaner's susceptibility to musculoskeletal problems (Woods & Buckle, 2006). Generally, cleaners do not have the ability to influence their work arrangements or to develop their occupational career. Conditions such as these decrease physical wellbeing and can increase the risk of psychological illness (Woods & Buckle, 2006). The psychosocial risks associated with the cleaning occupation also stem from low pay, low status, quality of their jobs in terms of work schedules (number and timing of working hours) and workloads (Campbell & Peeters, 2008; Zock, 2005). For the most part, cleaners work in isolation; they are responsible for stipulated tasks and areas (Woods & Buckle, 2006). Cleaners also usually have working hours that differ from standard working hours. These irregular hours increase their risk of harassment and excludes them from social activities such as coffee breaks (Zock, 2005).

As mentioned earlier, others in the working environment are significant to the work experience of cleaners. Woods and Buckle (2006) found that supervisors and colleagues were generally supportive of cleaners despite the fact that some lack of sympathy and interest from management was reported. On the other hand, other persons occupying the work environment, such as other staff and patients, were seen as more problematic. These groups were seen as having little appreciation for cleaning work and as being inconsiderate and rude. This speaks to the fact that as an occupational group, cleaners are particularly invisible and the times in which they become visible are when they are somehow at fault (Ehrenreich, 2001). Similarly, we often forget cleaners, but easily recognise when things have not been cleaned (Herod & Aguiar, 2006).

The mental health of these workers is clearly compromised by their jobs, and Søgaaard *et al.* (2006) describe how hospitals are particularly poor psychosocial

environments for cleaners, especially in terms of cognitive stimulus and possibilities for development. Cleaners are also prone to face traumatic events in this setting. Traumatic events are those that lie outside normal human experience and would cause considerable suffering for anyone (Buyssen, 1996). Bibby (1995), Buyssen (1996) and Mason and Chandley (1999) highlight a number of traumatic events experienced by healthcare workers: death, harassment, suicide, injury, aggression, violence and discrimination. As Zuberi (2011) notes, workers' emotional and psychological wellbeing are compromised by constant exposure to suffering, death and tragedy. Also, witnessing death or physical pain can be accompanied by feelings of guilt and helplessness (Raphael, Wilson, Meldrum & McFarlane, 1996). Mason and Chandley (1999) note that healthcare staff who experience trauma or violence are limited and restricted in their possible responses. Workers respond to feelings of depression, anxiety, anger, frustration or powerlessness by bottling them up (Stinson *et al.*, 2005). This speaks to another potentially negative psychosocial feature of hospitals: emotional labour.

Emotional Labour

"The management of human feeling during social interaction in the labour process" is what characterises emotional labour (Nixon, 2009: 305; Erickson & Ritter, 2001). It is the act of conforming to display rules and the management of feelings in line with organisational rules and subject to hierarchical control (Wharton, 2009; Hochschild, 2003;). Emotional labour can include enhancing, faking or suppressing emotions in order to modify emotional expression (Grandey, 2000). Also, moving beyond just the employee, James (1989: 15) defines emotional labour as "the labour involved in dealing with other peoples' feelings".

As a result of the rapid growth of the service sector, emotional labour is common and has garnered attention (Nixon, 2009; Ashforth & Humphrey, 1993), as it is central to service work (Hanser, 2012). This is partly because an emphasis on customer service is characteristic of the service economy (Nixon, 2009). Service work relies on workers controlling their emotions. Therefore, employers attempt

to control this process by making emotional management a job requirement and thereby turning it into emotional labour (Wharton, 2009). This extends beyond the individual worker as through their performance of positive emotions, service workers attempt to produce positive emotional states in customers in line with the demands of the organisation (Hanser, 2012).

According to Hochschild (2003), many different jobs require emotional labour, but they all have three aspects in common. One, face-to-face interaction with the public is necessary. Second, the worker needs to elicit an emotional response in another (usually the client). Lastly, an employer exercises control over the emotional responses of workers.

The customer is a source of joy and frustration for workers (Korczynski, 2003). In the workplace, angry and abusive customers form part of the social relations faced (Korczynski, 2003). Front-line service workers bare the brunt of customer anger (Korczynski, 2003). Management often 'condone' this type of customer behaviour because the customer is seen as sovereign and the service worker's job is to deal with customers (Nixon, 2009). This struggle is often more challenging for women. Historically, women have dominated the occupations in the service sector (Nixon, 2009). Service work is very gendered and often reinforces gender stereotypes and expectations (Hanser, 2012). Generally, women and members of lower level occupations have a lower social status and perform deferential forms of emotional labour (Erickson & Ritter, 2001). Due to this, women have a weaker 'status shield' against the emotions of others (Hochschild, 2003; Erickson & Ritter, 2001). Similarly, they are exposed to anger or frustration that should elicit a similar response. However, due to their position, they are required to manage and hide negative emotions (Erickson & Ritter, 2001).

Service encounters in low-level, interactive service jobs focus on the "social relations of work and the balance of power and control" (Wharton, 2009: 150). Service workers face unique forms of control and exploitation because they lack power and control (Wharton, 2009; Hanser, 2012; Hochschild, 2003). In

particular, low-skill employment is characterised by docility and deference on the part of the worker (Nixon, 2009). The expectation is that positive emotions are displayed to those of a higher status through interactions that are often monitored or controlled by employers (Wharton, 2009; Erickson & Ritter, 2001). In line with Hochschild's (2003) flight attendants, service workers generally have a 'fear hierarchy' through both customers and supervisors. Similarly, supervision is often indirect. Service workers fear what message will be passed on to their supervisors (Hochschild, 2003).

Emotional labour is challenging work. It has the potential to be sad and difficult. It requires the worker to give something of themselves (James, 1989). According to Korczynski (2003), service workers regard the pleasurable emotional labour of service interactions with their customers as especially meaningful. And when this interaction is unpleasant, it is even more frustrating (Korczynski, 2003). Emotional labour must be considered a job demand (Wharton, 2009; James, 1989). Comforting someone, listening to someone who is angry, sad or afraid is just as tiring as physical labour (James, 1989). Due to this, emotional labour can be detrimental to the wellbeing of workers (Erickson & Ritter, 2001). Attempting to conform to expected emotional expressions could result in harmful psychological effects (Ashforth & Humphrey, 1993). For one, it can lead to stress and burnout (Fineman, 2000). The trouble for service workers according to Hochschild (2003), however, is the fact that employers do not recognise emotional labour as a source of stress.

Context is an important consideration when unpacking emotional labour, influencing its content and form (James, 1989). In the hospital, doctors and nurses have to deal with emotional labour (Fineman, 2000). Caregiving is seen as a specific kind of emotional labour (Wharton, 2009). However, the hospital can sometimes be considered quite depersonalised and emotional work in the form of comfort, empathy etc. is sometimes not deemed central to its functioning. Despite this, emotional labour must take place in the hospital, but invisibly and unrewarded (James, 1989). Often ignored is the fact that domestic services can include emotional labour in terms of interpersonal skills (Abrantes, 2012). These

are often the same skills acknowledged and accredited in medical professions, but unappreciated in cleaning workers (Abrantes, 2012).

Summary

Hospital cleaning work is emotionally and physically strenuous (Zuberi, 2011). It is evident that cleaners are forced to adapt to a particular way of work in order to retain their position in the workforce. This necessity to adapt body and mind is typical of capitalism (Herod & Aguiar, 2006). It also speaks to alienated labour, which does not enable people to fulfil their humanity (Watson, 2003). It seems that for cleaners the very productive activity that should be pleasurable, fulfilling and rewarding ultimately becomes the source “of all that is wrong in life” (Yuill, 2005: 132). As a result of their contexts, private company cleaners’ work experiences are also likely to be shaped job insecurity and working poverty. The expectation is that the cleaning staff interviewed here will have similar work experiences in terms of the physical and psychosocial risks they have to engage with as well as a blatant knowledge of their ‘inferior’ position in the hospital hierarchy.

Chapter 4: Methodology

The questions being posed and the type of data one wishes to generate is the motivation for the choice of method (Punch, 2005). With my emphasis on gaining an understanding and accessing depth of experience, the qualitative methodology is employed as the means of developing findings that are convincing. As is the case here, focus on particular subjective experiences is especially appropriate in a case where the participants have generally been overlooked in traditional research (Haverkamp, 2005). In this chapter I discuss qualitative research methodology and its appropriateness to my project. I then describe the components of this methodology: my sampling, data collection and data analysis choices and steps in light of relevant literature.

Qualitative Research Methodology

Qualitative methods are intended to study the experiential life of people; “the life-world as it is lived, felt, undergone, made sense of, and accomplished by human beings” (Schwandt, as cited in Polkinghorne, 2005: 138). As human experience is multi-layered and intricate, it is especially challenging to study. Qualitative methods are designed to take these characteristics into account and to facilitate the investigation of these experiences (Polkinghorne, 2005).

The specificity of experience is the concern of qualitative research, not the establishment of generalisations (Haverkamp, 2005). Qualitative research provides the opportunity to explore issues/events and how those experiencing them understand them. Therefore, qualitative research starts with attempting to see things from the perspective of those studied before making more detached analyses (Fielding, 2006). I applied this two-step process in my study by first engaging in interviews in which I attempted to access the perspective of the cleaning staff. This was followed by ‘detached’ analysis. However, theory (and the requirements of a Master’s thesis) guided the manner both in which I sought out their perspectives as well as which perspectives I focused on. Some detachment was always present.

The functions of qualitative research have generally been seen as descriptive or exploratory. As Ritchie (2003: 28) states, “the essential purpose is to explore and describe participants’ understanding and interpretations of social phenomena”. Providing “knowledge for understanding” is the role of this type of research (Ritchie, 2003: 26). Another of the key intentions of qualitative research is to describe and clarify lived experience (Polkinghorne, 2005). With the aims of exploration, description and understanding, this project’s aims fall broadly into the qualitative research camp.

Sampling

Sites

As there are three types of hospital identified in South Africa, I tried to access interviewees at each level: district, regional and tertiary. My original intention was not to compare the experiences of workers from different hospital types, but I did wonder if there were any glaring differences in experience across these levels. This could indicate a facet of context to explore in more detail. I came to have interviewees from one district hospital (Karl Bremer Hospital), two regional hospitals (New Somerset Hospital and Mowbray Maternity Hospital) and two tertiary hospitals (Groote Schuur Hospital and Tygerberg Hospital). One interviewee was from the district hospital, five from regional hospitals and two from tertiary hospitals. Two of the hospitals are situated in the northern suburbs, two in the southern suburbs and one in the City Centre. The sites were chosen based on their location and my subjective knowledge of them. In particular, Groote Schuur, Tygerberg and New Somerset Hospital were chosen because of their size and prominence in the Western Cape. Mowbray Maternity Hospital was chosen based on its proximity to my place of residence and served as my first site to test my sampling technique.

Sampling and Sample Size

The sample for my project consisted of eight female hospital cleaning staff: seven general workers and one supervisor¹. The size of my sample was determined by a number of factors: access to participants, time constraints as well as a level of theoretical saturation. Each of the participants was purposively selected based on their ability to provide me with answers to my research questions. Needing to select very specific participants, I adopted non-probability sampling techniques.

For qualitative research, interview participants need to be selected using purposive and iterative sampling strategies (DiCocco-Bloom & Crabtree, 2006; Polkinghorne, 2005). The basis for participant selection in qualitative research is because they are able to make considerable, relevant contributions to elucidating the experiences under investigation (Polkinghorne, 2005; Kumar, 2005; Judd & Kidder, 1991). Therefore, in selecting participants it is important that they are 'qualified' to provide credible information and are willing to openly share their story (Turner, 2010).

Interestingly, Polkinghorne (2005) argues that the word 'selection' is more applicable than 'sampling' when discussing qualitative research. This seems to be apt in my case too. Participants were selected based on their meeting the criteria of the research question and their accessibility. As DiCocco-Bloom and Crabtree (2006) state, the sample of interviewees needs to be relatively homogenous especially in terms of characteristics related to the research question. My research is focused on cleaning staff from private cleaning companies at public hospitals in Cape Town. Individuals were approached and invited to participate in the project if they met these criteria.

Accessibility also played a key role in my choice of participants. To start, I went to Mowbray Maternity Hospital located near my home to test whether or not I could find willing participants. I inquired at security about the times at which the

¹ See Appendix B for brief profiles of each participant.

private company cleaning staff leave the building and which exit they used. I then waited for them to leave the hospital premises and approached them with my 'Participant Information Sheet' (Appendix A). I asked people if I could have a moment of their time. If they said yes, I quickly explained what I was interested in chatting to them about. I offered them the information sheet for more detailed insight into the project. If they were willing for me to call them to confirm whether they would in fact like to participate, I took down their first names, contact numbers and a time of day that would suit them for me to call. I approached eleven people at Mowbray Maternity Hospital and most of them were willing to consider participating or said they would consider it. Armed with several names and contact numbers, I felt very confident about my ability to recruit participants.

Setting up interviews with these potential participants was much more difficult than meeting them. I gave them a day to think about participating and then made many phone calls. Some telephone numbers simply rang, regardless of what time of the day I called and other people found it difficult to fit me into their schedules. I did, however, manage to secure two interviews from this initial group of potential participants.

I made use of this same recruitment strategy at Tygerberg, Groote Schuur and Somerset Hospitals. As I have family and friends who are familiar with these hospitals, I could find out what time the private company cleaning staff would be leaving work. I would then wait outside the buildings or gates to approach them. This strategy was much more difficult at Tygerberg and Groote Schuur where there is a constant flow of people using multiple exits off the hospital premises. I would approach anyone leaving the building not in a nurses' uniform, which meant I chatted to a number of visitors and students as I tried to find private cleaning company cleaners. At each hospital visit I got four sets of details. Again, securing the actual interview was more difficult. In terms of Karl Bremer Hospital, I was somewhat lucky. I had spoken about my project with a cleaner in my building who said she knew a cleaner at Karl Bremer. She mentioned my

work to this woman who was willing to have me call her to explain the project and ultimately meet up with her.

In terms of the size, with purposive sampling, the idea is to reach out until the sample has reached the designated size (Judd *et al.*, 1991). I did not have a predetermined necessary sample size, but would have liked to have a sample of ten women. Due to difficulty in accessing more participants as well as time constraints, my sample size only reached eight. I was comfortable with this fact, however, because the themes across my reviewed interviews appeared to be similar. This is somewhat in line with the idea of theoretical sampling or saturation. As no new categories or themes emerge (saturation) it is possible to stop finding new participants (Siganporia, 2011; Pope, Ziebland & Mays, 2000).

Data Gathering

My means of data collection was the qualitative interview. In total I conducted 11 interviews: eight initial interviews and three follow-up ones. My research aims as well as the type of information I wanted to use as evidence – the cleaner's own words, as well as the manner in which I wanted to engage with my participants made qualitative interviewing the appropriate choice of method. Below, the various characteristics of the qualitative interview are discussed in light of what I did.

The Qualitative Interview

Qualitative research involves collecting intense, rich and thick descriptions of the experiences being researched (Polkinghorne, 2005). Another of the key features of qualitative methods is the attempt to view and describe circumstances and experiences from the point of view of the interviewees and in their own words/terms (Ritchie, 2003). The aim of data gathering in qualitative projects is to offer evidence for the experience being investigated, as well as evidence that the experience is of a particular kind (Polkinghorne, 2005). In other words, what types of experiences are evidence and characteristic of alienation, job insecurity

or working poverty? This evidence comes in the form of the accounts participants give of their experiences, which are then analysed to generate a fundamental description of these experiences (Polkinghorne, 2005).

Knox and Burkard (2009) and DiCicco-Bloom and Crabtree (2006) point out that interviews are an increasingly important tool in qualitative research, often acting as the key means of data collection. Qualitative interviews aim to explore understandings shared by a particular group (DiCocco & Crabtree, 2006). Seidman (1991, as cited in Knox & Burkard, 2009: 566) also states that, "at the root of ...interviewing is an interest in understanding the experience of other people and the meaning they make of that experience". With these objectives, qualitative interviewing is an appropriate method with which to gather data for this study. These objectives match my research aims and the type of information I wanted to acquire.

In the hopes of obtaining this type of thick, rich data with a qualitative investigational perspective, interviews can take a number of forms (Turner, 2010). As Di-Cocco-Bloom and Crabtree (2006: 317) state, "the in-depth interview is meant to be a personal and intimate encounter in which open, direct, verbal questions are used to elicit detailed narratives and stories." The qualitative interview is generally a planned conversation (one with a general path of inquiry and semi-structured questions) that is going to be conducted in a similar manner for all participants (Babbie & Mouton, 2007). This is the method of data collection I adopted, a semi-structured qualitative interview. The interviews were based on a pre-determined set of open-ended questions, while subsequent questions arose through the conversation (DiCocco-Bloom & Crabtree, 2006).

As is most common with this approach, I made use of standardised open-ended questions, guided by a topic list (Turner, 2010). On the one hand, these types of questions ensure that the interviewees are able to express their viewpoints and experiences (Turner, 2010). On the other hand, having a general interview guide is beneficial as the same general topics of focus are discussed with each

interviewee. Despite this basic structure, adaptability is possible in the manner in which questions are phrased. I made sure to suit my phrasing of questions to the situation and participant (Turner, 2010).

The interviewing process is open and flexible so as to allow the researcher to probe interviewees' stories in more detail and pick up on emerging themes (Knox & Burkard, 2009). I tended to cover the same key themes in my interviews, but at different moments as my interviewees' narratives led towards them. To some extent, I also followed the interviewees' digressions as these identify what they are particularly concerned about, interested in or knowledgeable about (DiCicco-Bloom & Crabtree, 2006). Despite some level of structure, I felt that the qualitative interview was a process, one that was flexible, iterative and continuous (Babbie & Mouton, 2007), a negotiation between the participant and I.

The Nature of My Questions

Semi-structured interviews involve the development of open-ended questions, before data collection, based on the focus of the project (Knox & Burkard, 2009). Specific information is sought and the intention is to be able to compare the responses of various participants (Knox & Burkard, 2009). Questions need to be constructed in a way that keeps participants on focus with their responses. Follow-up questions or prompts are necessary to generate optimal answers from interviewees (Turner, 2010). Turner (2010) identifies McNamara's suggestions for constructing effective interview questions². According to McNamara,

² According to McNamara (as cited in Turner (2010: 257), for effective interview questions: "(a) wording should be open-ended (respondents should be able to choose their own terms when answering questions); (b) questions should be as neutral as possible (avoid wording that might influence answers, e.g., evocative, judgmental wording); (c) questions should be asked one at a time; (d) questions should be worded clearly (this includes knowing any terms particular to the program or the respondents' culture); and (e) be careful asking "why" questions".

I attempted to follow these guidelines in constructing my interview questions and in asking them during the interview. In particular I tried to break down complicated terminology into manageable parts. For example, instead of asking about job insecurity, I asked about fear of losing one's job, what factors contributed to these feelings and so on.

DiCicco-Bloom and Crabtree (2006) highlight that interview questions usually change during the research process as the interviewer learns more about the subject and the participants. This was the case for me. As I did more interviews I was able to reconstruct problematic questions and identify questions and/or probes that worked particularly well. Some questions were removed completely and others were added (DiCicco-Bloom & Crabtree, 2006). This again serves to demonstrate the iterative nature of qualitative research.

The Interview Process

Turner (2010) also points out McNamara's eight principles for the preparation stage of the interview process³. These served as a useful guide when engaging with the interview process. I attempted to conduct my interviews in spaces that were convenient for my participants. Of my 11 interviews, I conducted seven in interviewees' homes, two in a park near Mowbray Maternity Hospital and two others in my car. The two interviews that were done in my car were both done at the suggestion of the interviewee. Both interviewees' homes were occupied at the time I came to visit and they asked if we could talk in my car. While not my first choice of location, this seemed to be the most practical choice for the interviewee and a choice they felt comfortable with.

³ McNamara's principles for engaging with the interview process: "(1) choose a setting with little distraction; (2) explain the purpose of the interview; (3) address terms of confidentiality; (4) explain the format of the interview; (5) indicate how long the interview usually takes; (6) tell them how to get in touch with you later if they want to; (7) ask them if they have any questions before you both get started with the interview; and (8) don't count on your memory to recall their answers" (Turner, 2010: 257)

In each of these interview locations, ambient noise was a problem. This was most problematic for me during the transcription process and not during our conversations. Cars, people and especially the wind affected the sound quality of the interview recording. In their homes, interviewees were often not able to secure a quiet place for us to use. Spaces often served multiple functions and were used by multiple people so we could not cut it off to the rest of the household. People and the television were the noisiest parts of the home interviews. While noise was a problem in terms of transcription, I did not feel that it distracted my interviewees. My only concern is that in spaces where there are family members or friends moving in and out, their level of disclosure may have been compromised. The level of privacy they felt may have affected what they said or how they said it.

I began the interviews by going through my information sheet and describing what my project is about. I worded my interests as simply related to their work experiences and emphasised that I was interested in learning more about these. If they asked, as only one or two interviewees did, I went into more detail about my project. Other things I mentioned upfront were their ability to decline to answer questions and that, to the best of my ability, their privacy would be maintained. Lastly, I explained why I needed to record the interviews and asked their permission to do so. Each of the participants was willing to continue the interview after this explanation.

My first set of questions was related to demographic information: age, marital status, number of dependents, schooling and so on. I then asked questions about previous employment and how they came to their current job. During this portion of the interview I made an effort to ask questions based on what the interviewee was saying instead of following my topic guide. With Glenda⁴, a Zimbabwean citizen, we started discussing what it is like to find a job in South Africa, while with Crystal we began chatting about the change in private cleaning company contracts that she had heard would be taking place at her hospital. This

⁴ A pseudonym. All participants were given pseudonyms in an attempt to ensure anonymity. This will be elaborated on when ethical considerations are discussed.

is one of the ways in which I aimed to establish the interviewee as the authority in the interview– by not simply posing predetermined questions, but by letting their contexts, experiences and interests guide the manner in which we discussed issues.

I took hand-written notes during my interviews. These were not comprehensive, but based on key words used or topics I would like to discuss. I avoided too much continuous note taking because it appeared to distract interviewees. After the interview I would write down my overall key impressions and insights or put them into a voice recording on my cellular phone. The voice recording method was something I had never done before, but as I was leaving one interviewees' home, I felt the need to let out what I was feeling. As I was driving and could not write, I used the voice recording function on my phone. This method was useful in terms of being able to just speak and not worry about writing anything in clear sentences. It was also helpful in being so immediate, I felt like it was my real emotional response to the interview. These notes and recordings were later used to identify more interview questions as well as aid me in my data analysis.

The Interview Dynamics

The iterative nature of the qualitative interview identified above makes the interviewee-interviewer relationship extremely important – it is both the means by which information is collected, and by which the validity of this information is strengthened (Knox & Burkard, 2009). Studying experience and generating sufficient data necessitates a rigorous exploration with the interviewee (Polkinghorne, 2005). Vulnerability on the part of the interviewee is likely as they reveal personal information, feelings of stress, fear or embarrassment or feel as though they are being evaluated (Knox & Burkard, 2009). At times feelings of insecurity seemed to arise when we discussed level of schooling or unplanned pregnancies. Also, discussing working relationships with others sometimes made the interviewees feel embarrassed, fearful or angry. In order to encourage openness and full disclosure, participants need to feel that their experiences are validated and supported and that the researcher is being equally

open (Knox & Burkard, 2009). I revealed as much about myself in the interview as was possible and relevant and did not avoid answering questions interviewees posed. I was also advised to sometimes ask questions about cleaning staff in general as this distance could encourage more disclosure.

Non-verbal information is also assessable in a face-to-face interview. These include facial expressions, gestures and other non-verbal cues that can enhance the meaning of what is said (Knox & Burkard, 2009). Shakes and nods of the head were definitely the most identifiable form of non-verbal information I acquired. Also, descriptions of events usually involved hand gestures to give me a sense of magnitude. Being able to see a non-verbal reaction to something allowed me to probe. This may not have been possible if I had not been face-to-face with the interviewee. Another benefit of face-to-face interviews is the ability of the researcher to clarify anything that is being said. This helped me in my interpretations as I used English in my interviews and this was sometimes not the participant's first language.

A common assertion is that rapport is created in a face-to-face interview. As a concept, rapport concerns trust and respect for the interviewee and what they are sharing as well as the establishment of a safe and comfortable environment in which this sharing can occur (DiCocco-Bloom & Crabtree, 2006). This has the potential to encourage participants to chat about their experiences more freely (Knox & Burkard, 2009). Rapport needs to be created quite quickly in order to aid the qualitative interview process (DiCicco-Bloom & Crabtree, 2006). For the most part, I felt that this was the case. In meeting my potential interviewees at their place of work and getting to describe my research in simple terms I felt that I was able to encourage participation. Also, I think that my personality and casual approach was an asset – allowing them to feel comfortable. Being a relatively young woman of colour assisted me. I was able to play the part of learner more easily. I also think that being women of colour themselves, my interviewees felt that in some ways they could relate to me. For, as DiCicco and Crabtree (2006) established social roles play a part in the interview process and its outcomes. Overall, the face-to-face interview worked well for me.

The ability to build rapport between the researcher and participant is one of the key advantages of conducting multiple interviews. This might allow the interviewee to feel more comfortable discussing traumatic experiences as there is some level of trust (Knox & Burkard, 2009). Knox and Burkard (2009: 569) describe why they utilise a minimum of two interviews in their qualitative research,

Doing so increases our chance of understanding the context, and thus the meaning, of participants' experiences; helps participants feel a sense of safety with the interviewer; allows examination of additional content that may have been stimulated by the first interview; and enables either party to clarify any potentially confusing elements of a first interview.

In qualitative research that adopts an interview approach, single interviews are most common (Knox & Burkard, 2009). Single interviews are used when interviewees are tough to access or when only one interaction is necessary. With my participants, the former was the case. There is the chance, however, that single interviews miss information. Multiple interviews are sometimes preferred because of this.

My participants were relatively difficult to access, but I did want to make use of follow-up interviews. Also, as I spoke to other cleaners, key ideas/themes emerged that I wished to go back and address or explore further. Based on the availability and willingness of respondents as well as time constraints, I was only able to conduct three follow-up interviews. Two respondents indicated that they were too busy to meet up with me again, another two were no longer contactable via telephone and I was not able to set up suitable meeting times with the remaining respondents. Despite this, the follow-up interviews that were conducted were very useful in that they served as a member-check of sorts. I could bring up key themes I had noticed and see whether these were legitimate in the eyes of the cleaners. I could summarise some of my key insights and see if these were considered valid. Also, I could clarify bits of information that I was unable to hear on my recordings or that did not immediately make sense to me.

For example, a number of interviewees mentioned the 'Sluice Room'. It was only during a follow-up interview that I was able to clarify what this was: a room where cleaners dispose of human waste and clean dirty linen.

Data Analysis

As DiCocco-Bloom and Crabtree (2006: 314) note, the qualitative research interview contributes to a "body of knowledge that is conceptual and theoretical", but that is grounded in the experiences and meanings of these experiences to the interviewees. Therefore, through this method I hope to broaden the knowledge and understanding around the experiences of these cleaners from their own point of view. My data analysis was therefore grounded in the transcribed interview material.

"In most qualitative analyses the data are preserved in their textual form and 'indexed' to generate or develop analytical categories and theoretical explanations" (Pope *et al.*, 2000:). This is the case in this project as the raw data generated from the interviews is in the form of transcripts and notes (Pope *et al.*, 2000). Here the transcribed text acts as the proxy for the cleaners' experiences. The data also serves as the basis on which findings are made; excerpts from interviews are utilised to illustrate findings and demonstrate how these were uncovered from the evidential data (Polkinghorne, 2005).

Data analysis is ultimately researcher driven. Pope *et al.* (2000) posit that the interview transcripts provide a description of experiences, but not any form of interpretation. I would then need to make sense of the data and generate meaning in light of my research questions (Pope *et al.*, 2000). Similarly, they state that: "To take the analysis beyond the most basic descriptive and counting exercise requires the researcher's analytical skills in moving towards hypotheses or propositions about the data" (Pope *et al.*, 2000:). While I agree that the researcher is a very active part of the analysis process, interpretation and meaning generation occur during the interview process as well. The participants interpret their experiences in light of my questions. I then also reflected my

understanding of their experiences back to them in order for us to generate a mutual interpretation of these experiences.

Being part of an iterative process, data analysis is not seen as an isolated stage in the research process, but something that is done in parallel with data collection; taking place in order to generate an emerging understanding (Siganporia, 2011; DiCicco-Bloom & Crabtree, 2006; Pope *et al.*, 2000). For example, during my interviews new interview questions were developed as themes emerged and key avenues of inquiry became apparent (DiCicco-Bloom & Crabtree, 2006; Pope *et al.*, 2000). The data gathered continued to shape the data collection process (Pope *et al.*, 2000). For example, it was in one of my earlier interviews with Crystal that the issue of the difference between cleaners employed by private cleaning companies and those employed by the government was raised. I probed this relationship in my following interviews and this emerged as a major theme.

The 'main' analysis was still a daunting prospect. The pages and pages of transcribed interviews were very intimidating. To make this process more manageable I was directed to the analytical scaffolding of Spencer, Ritchie and O'Connor (2003), which I then used to approach the data analysis phase. Spencer *et al.* (2003) refer to the 'analytical hierarchy' in qualitative research analysis. "The hierarchy is made up of a series of 'viewing' platforms, each of which involves different analytical tasks, enabling the researcher to gain an overview and make sense of the data" (Spencer *et al.*, 2003: 213). Applying the analytical hierarchy as an analytical framework involves three stages: data management, the production of descriptive accounts and the production of explanatory accounts (Spencer *et al.*, 2003).

The data management stage involved reviewing, labeling, sorting and synthesising the data resulting in a set of themes and concepts (Spencer *et al.*, 2003). What this meant for me was first transcribing the interviews from the recordings. I transcribed each of these recordings myself as a means of immersing myself in the data (Siganporia, 2011). I then familiarised myself with the transcripts –reading the transcripts and notes in order to gain a sense of the

data (Pope *et al.*, 2000). The transcribed interviews were read and re-read in order to identify and index themes and categories (Pope *et al.*, 2000). Sections of text with similar content were separated into different categories; these were later distilled to form the major thematic areas (DiCicco-Bloom & Crabtree, 2006). From this, I was left with an index of the data labelled into manageable segments (Pope *et al.*, 2000). The next stage of data analysis was to separate these segments of text from the original transcripts and group them under the key thematic areas identified (Pope *et al.*, 2000).

Then, the descriptive accounts stage of my analysis involved using the indexed data to identify key dimensions, mapping experiences as well as creating classifications, categories or typologies (Spencer *et al.*, 2003). Once the themes were identified, I attempted to analyse them in more depth. I tried to pick up on commonalities and associations across the transcript segments as well as the range and characteristics of experience (Pope *et al.*, 2000).

As Pope *et al.* (2000:) note: “qualitative research uses analytical categories to describe and explain social phenomena.” The categories used in my project were derived both deductively and inductively. The prior was derived through applying the themes evident in the literature and the aims of my project. The latter was generated through the data itself as interviewees identified issues and experiences as well as through the notes I had made (Pope *et al.*, 2000; DiCicco-Bloom & Crabtree, 2006). So, to some extent, the interpretation of data is based on emergent themes where the interview data leads to the ‘theory’ inductively.

Lastly, I approached the explanatory accounts stage. Here the intention was to generate explanations for why the data took the form it did (Spencer *et al.*, 2003). This stage was largely based around my efforts to understand the experiences of these cleaners. This stage involved the most detached assessment of the data and was largely informed by the literature.

Ethics

Haverkamp (2005: 149) states that, “The philosophical basis of research ethics is ultimately premised on the fact that our research requires that we locate people who, to serve our research objectives, are willing to share information about themselves, information that is often of a highly personal and intimate nature.” This is a reality that I have always acknowledged as a qualitative researcher, but one that only really makes sense once you begin engaging with participants. As each interview progressed, the reality of the ethical issues that need consideration became more apparent. Also, the extent to which the basic ethical checklist of confidentiality, privacy, informed consent and so on, is by no means sufficient stood out for me. In this section (with reference to literature), I identify some of the ethical choices I made prior to conducting my research as well as those choices made during the course of my project.

In the most general sense, ethics is concerned about “doing good and avoiding harm” (Orb, Elsenhauer & Wynaden, 2000: 93). Behaving ethically means being open to other people, acting in their best interests and trying to see others as they are, rather than imposing one’s own ideas and biases on them (Brinkmann & Kvale, 2005). Microethics considers the relationship in the interview while macroethics deals with “relations to society and culture at large” (Brinkmann & Kvale, 2005: 157). Microethics is what Guillemin and Gillam (2004) describe as “ethics in practice” or the everyday ethical issues that arise in the doing of research. A distinction is made between procedural ethics and “ethics in practice” (Guillemin & Gillam, 2004). This has proven to be a significant distinction. In light of the nature of qualitative research methods, ethically relevant moments are more numerous and the dominant ethical considerations (procedural ethics) were most definitely not sufficient in covering the ethical issues that arose during the course of the research project (ethics in practice) (Guillemin & Gillam, 2004; Haverkamp, 2005).

Some of the key ethical issues in conducting qualitative research are competence, multiple relationships, confidentiality, informed consent, privacy, preventing

harm and not accessing the field deceptively (Haverkamp, 2005; Ramcharan & Cutcliffe, 2001; Orb *et al.*, 2000). Orb *et al.* (2000) identify respect for people (autonomy), beneficence and justice as universal ethical principles. In terms of respect for people, participants' rights need to be recognised. This includes their right to informed consent and choices of participation or withdrawal (Orb *et al.*, 2000). Beneficence refers to the idea of doing good for, and avoiding the harm of, others (Orb *et al.*, 2000). Here privacy and confidentiality are important and the use of pseudonyms is recommended (Orb *et al.*, 2000). Justice is concerned with fairness and avoiding the exploitation of participants (Orb *et al.*, 2000). It is important to recognise both the vulnerability of participants as well as their contributions to the study (Orb *et al.*, 2000).

Due to the fact that those who are willing to take part in the interview process are viewed as participants, informed consent is important (Guillemin & Gillam, 2004). Informed consent means that participants need to be made aware of "reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects" (Haverkamp, 2005: 154). Consent is a negotiation of trust (Orb *et al.*, 2000). Importantly, informed consent needs to be re-negotiated and re-established throughout the course of the project, not simply in the beginning (Haveramp, 2005; Ramcharan & Cutcliffe, 2001; Orb *et al.*, 2000). I attempted to establish informed consent through my participant information sheet and through my telephone conversations. Through these I tried to make sure that potential participants knew the purpose of my study was academic and was not likely to affect their work situation.

When making ethical considerations, the key focus is on the relationship between the researcher and the participant (Haverkamp, 2005; Orb *et al.*, 2000). While the decision to participate in the project is the participants, the individual interviews conducted during the course of the project are done at the request of the researcher in order to serve their goals. This acknowledgement is an important one to make and the implication of this researcher-driven interaction is a power dynamic that cannot be ignored (Haverkamp, 2005). While

emphasising the fact that I initiated interviews, the interviewee decided on the time and venue. My intention was to give them some control of the process and hopefully some sense of control.

In the hopes of ensuring that my project was conducted in line with ethical principles, I followed a number of the common rules in qualitative research. The ultimate intention is that trust is established and maintained (Ramcharan & Cutcliffe, 2001). Within the scope of the project it is the responsibility of the researcher to support the wellbeing of the participant and to guard them from any possible harm (Haverkamp, 2005). In light of the vulnerability of participants, this trustworthiness is important (Haverkamp, 2005). Some of the ethical guidelines assisted in this regard. Being upfront about who I was and what I was doing when I met my respondents was one means of attempting to establish trust (Sarantakos, 1998). I then attempted to maintain this by following through on each of the actions I said I would. For example, I made sure to call or message respondents within the timeframe I gave and I provided them with copies of their transcripts as I said I would. Also, I did not approach or interview the participants in their workplace to ensure that their participation in the study was a private matter and that it would not negatively affect their working life. It was interesting to note, however, that one pair of participants did share their experiences of the interview with one another. So at least to them, participation in the study was not perceived to be detrimental to their work. Similarly, those who I interviewed a second time had some time to make that decision. It could be said that they perceived me to be trustworthy and that they did not see my project as harmful.

The researcher also needs to be upfront about who will have access to the information generated in interviews and in what forms (Haverkamp, 2005). Before the interview began I made it clear that the information gathered was for academic purposes and that myself, my supervisor and examiners would read my project and that others would have access to it via the University's library. I also let them know that the interview recordings were solely for my use; serving the purpose of capturing all that was said during the course of the interview so

that I could transcribe it later. Through the use of the information sheet and conversation, participants were able to get a sense of the purpose of the research, the nature of the topics to be covered in interviews and their right to confidentiality and choice to leave the study or not answer a specific question at any time. They were also made aware of the scope of the project and the fact that I could not improve their work situation in any way. Despite my perception that I had made the above clear, I cannot be sure whether participants felt comfortable to skip an interview question or leave the study. I also noticed that a number of participants hinted at the idea that I might have alternative employment for them, despite the fact that I had indicated that I could not change their work situations. This expectation on their part may have influenced their willingness to participate in my study.

The above examples touch on the thing that has stuck with me the most throughout this project; that “good intentions alone are not a reliable guide to ethical choice”(Haverkamp, 2005: 146). Ethical guidelines are simply insufficient in dealing with the ethical matters that arise during the course of the research project. Ethical dilemmas in qualitative research are often subtle and nuanced (Orb *et al.*, 2000). The ethical issues that could arise during the course of an interview are not often very predictable, and it is the task of the researcher to be aware of and sensitive to this (Orb *et al.*, 2000). Brinkmann and Kvale (2005) believe that ethical proficiency in qualitative research is not simply about following the common ethical principles, but rather about contextualized reasoning on ethical matters.

One of the challenges of interviewing participants is the desire to probe and dig for meaningful information that needs to be accompanied by the ability to make interviewees feel safe enough to discuss trying experiences (Knox & Burkard, 2009). The researcher and the interview process are likely to have an effect on the participant (Orb *et al.*, 2000). There is the probability that the interview will touch on issues that participants did not expect, that they find upsetting or that unsettles their perceptions of their situations (Haverkamp, 2005). Haverkamp (2005) similarly notes that the researcher can slip in and out of the world they

are investigating. The participants themselves live in these worlds making escape much more difficult. I found both of these insights to be true, as well as one of the most difficult things to deal with during the interview process. For example, Shakira⁵ said,

Like the way you were interviewing me now..., its like almost like now I can feel really what a cleaner is. Like it's almost like you didn't sit before one day you were just sitting and think now what is it to be a cleaner you see. But now the kinds of things you were asking me now it's almost like you feel sore inside because now you can experience it and you can see really what are you really as a cleaner. ... But I didn't think before like this but now you were interviewing me it's heart sore because like now you can see what really are you as a cleaner. You are really a nothing because you must just clean there wherever it's dirty you must just clean it... But now like I really say, the way you were interviewing me it's almost like inside if I answer you like what are we really for them? It's like then it made me a little bit cross you see, but I never thought about it; sit still and think what is it, what things must you eat up everyday to be a cleaner you see.

On the one hand, I was encouraged by the fact that she had gained a different perspective on her position, and that she was taking something away from the interview. On the other hand, I felt guilty for having made her feel so dispirited about her work situation. What added to my guilt was my helplessness in the situation. My response to her comments was only to clarify that my intention was never to make her feel bad about her job or circumstances and to emphasise the scope and importance of her job. To this she responded,

Huh uh⁶, I'm not feeling bad. It was just now for like say a five minutes you see. The way I'm answering you and the way like I was thinking about it really what is it to be a cleaner, but no, I feel fine because I'm just knowing it myself that I'm doing it for the patients you see. I don't care whoever is taking it for nothing, but I'm just doing it for the patients. And like I must do my job, I must work for my

⁵ All quotes from Shakira are taken from interviews conducted on the 27 November 2012 and the 3 January 2013.

⁶ No [translated]

parents you see. So there is nothing you can do. You can't leave your job until you find another job you see.

While I took some comfort in this, her response is much more a reflection of her personal perseverance than it is of my ability as an interviewer.

Another important ethical acknowledgement is that each decision in the research process was made by me in light of what I believed would allow me to answer my research question. As Clough and Nutbrown (2007: 80) state: “the methodology which drives the research is as much to do with personal values as it is to do with ‘rigour’ and ‘hygiene’ in research”. Kvale (2004, as cited in Brinkmann & Kvale, 2005) identifies a number of the neglected ethical issues in qualitative interviews. These issues are mostly based on the fact that the interview process is serving the purpose of the researcher and that this fact should not be ignored. He notes that the power relation of the interview is unbalanced, that the interview involves one-way questioning, the interview serves an instrumental purpose, which may mean the use of manipulative dialogue and the interviewer has monopoly over the interpretation of data. Specifically related to the latter, research is undertaken with certain theoretical assumptions. Ritchie (2003: 25) states: “the collection of evidence is informed by theory and interpreted in light of it.” This means that I decided what was important and valuable information, not the participant. I therefore probed where I saw fit and changed the topic when comments were not in line with what I was trying to find out. This is an important acknowledgement to make.

Lastly, I have to be upfront about the fact that I am the one who benefited from the interview process. While my intention is to shed light on these workers' experiences, my research is not going to directly benefit them in any way (Guillemin & Gillam, 2004). Despite common beliefs that qualitative research is inherently ethically 'good' (Brinkmann & Kvale, 2005) and the naïve hope that all research is bound to help somehow, I must honestly admit that I feel that this is not the case. While I feel that I covered myself in terms of the procedural ethics of qualitative research, and that my intentions were ultimately good, I do not

believe this speaks to all the deeper ethical dilemmas inherent in research for the purposes of postgraduate study.

Summary

This chapter identified why making use of a qualitative methodology through the qualitative interview was appropriate for this project. Its character served to meet my aims and allowed me to answer my questions. The foregrounding of the participants' voices and the acknowledgement of the subjectivity of experience were also particularly important to me. Having conducted, transcribed and analysed 11 interviews with eight women from five different hospitals, my findings are presented next. These need to be understood in light of what has been discussed here. An understanding of the interview process, dynamics and questions as well as the ethical moments allows for a more critical understanding of my findings as the collection of data and analysis were shaped by these.

Chapter 5: Cleaning Up: Cleaners' Activities, Interactions and their Perceived Effects

This chapter identifies what cleaning work entails, giving us a sense of what cleaners do every day. It then focuses on what cleaning in the hospital means for, and to, these cleaners and their experiences. Related to these activities and interactions, the physical and psychosocial well being as well as the health and safety concerns of these cleaners are addressed. The invaluable nature of the work done by these private company cleaners is apparent, and so too is their marginalised and vulnerable position in the hospital.

The Daily Grind: What cleaning in the hospital entails

Cleaning at a public hospital involves a number of tasks. Some common aspects of cleaning are: sweeping, mopping, buffing, wiping, scrubbing, polishing and dusting; the same as typical cleaning activities identified in the literature. These activities are emphasised differently across the hospital. In the offices, cleaning largely involves picking up papers off the floor, while when cleaning in the wards the emphasis is on dusting and mopping. Similarly, the passages and corridors are where most of the buffing takes place. Aside from the wards, offices and corridors, some of the cleaners I spoke to also worked in the toilets, kitchens, students' quarters and tearooms. Depending on where they work, cleaners also generally wash linen, clear bins, secure medical waste boxes, maintain cleaning equipment and serve food. Dawn⁷ notes the distinctive job descriptions associated with different parts of the hospital:

Because we did job descriptions that we must work according to our thingy that we have; our...form. Because it can be a hospital but every dinges⁸ got a different thing. If you go in theatre then you will see 'Oh! I didn't know' You always learn something new if you go, that's why they move us. They change us a lot because it's not the same on every ward.

⁷ All quotes from Dawn are taken from an interview conducted on the 5 November 2012.

⁸ thing [translated]

This distinction carries through to the types of cleaning issues cleaners need to deal with. Susan⁹ identifies some of the things cleaners work with in the wards:

We working with urine, we working with po-po's, blood; especially blood. If you are working in Labour Ward you are going to work with blood. If you are working in Trauma, there is blood. All wards, there's always blood and then the po-po, the sluice linen. The nurses they change the linen, now this patient maybe passed away so that patient did dirty that linen. That linen needs to be changed. The clean linen needs to go to the on top of the bed. Then you you must go and do the sluice and take the tap and the water running, gloves and you must put a mask on and an apron. Then you start to do this. But to do that it's a lot of, how can you say, you need to put the gloves on, you need to close your face and put a apron because you going to do work with sluice. You do work with urine, you work with everything, vomit. You work with po-po's because it's a hospital so this kind of thing...

Working with blood, faeces and urine came up in a number of interviews, Trauma Ward is, “the place you see everything” [Stacey¹⁰]. Here cleaners see knife wounds, broken bones, broken necks and car accident aftermath. Depending on where you work, seeing dead bodies, people dying and stillbirths is also to be expected. Joyce¹¹ shares an example:

They just told us we must go mop there when they were finished with the operation you know. And when we go mop there I thought it was blood, but when you see that coming out of a person. That, it was looking like mince. Even at Maternity, Labour Ward, you must clean there then this girl is screaming, 'Aah'; she's in labour. And when she's finished, okay, that's a woman's smell; dirty when she's giving labour finish, and you must clean there and she sit oop bene daar. Jy sien al die dinge daar¹².

It is evident that there is a significant amount of work to do in the hospital. As Susan says, “There is a lot of work”. Cleaners ‘do a lot of things’ and describe

⁹ All quotes from Susan are taken from an interview conducted on the 26 November 2012.

¹⁰ All quotes from Stacey are taken from an interview conducted on the 27 January 2013.

¹¹ All quotes from Joyce are taken from interviews conducted on the 18 December 2012 and the 2 January 2013.

¹² open legs there. You see everything there. [translated]

themselves as being 'everywhere'. What is also apparent from my conversations with these cleaners is that not only do their daily tasks extend beyond 'cleaning', but also well beyond their job descriptions. Going to the shops for nurses or patients, making others tea, washing dishes, ordering cleaning supplies, serving food and changing linen are some of the other tasks they complete that are not technically part of their jobs. Shakira describes some of this "extra stuff":

Because my actual job that I must do is just clean you see. Like when the food comes in that is the housekeepers, but if my job is finished I can help the housekeeper out. You see so it's like that. But that is the extra things we are also doing we must see for the patients also. But we are cleaners. The nurses is there to see for the patients but if the nurses is not around, you as a cleaner is always around mos¹³ you must check if there is clean and here is clean and the bins is clean. Then you must give the water and you give the food for the, the food get cold now they don't want to eat it now later they call you, 'Oh sorry, come warm this food for me'. Then you must warm the food you see. So that is extra stuff. Or like they say, 'Oh I'm getting cold can't you bring me another blanket?' or 'I need a nighty' you see so that is all the extra things that we are doing. So we are everywhere in that hospital.

Similarly, Joyce, who works alone in the Outpatients Department (OPD) of her hospital, does most of the housekeeper's work because no government cleaner has been assigned to that department. She describes,

I'm a cleaner general worker. I'm just supposed to... Actually, I know my rights, but I'm actually just supposed to clean there. You know the linen that I go change, that is the housekeeper's job. The hand towel and the hand soap and the ordering of the cleaning, that is the housekeeper's job. I'm not even supposed to do, you know what that nurses there, I clean the tearoom. I will do it for them, but they like for instance they just sit and eat, their cups and that they just leave it there then you must clean it and my matron told me, that is not your job, they must clean their own cups and whatever they use.

In this quote Joyce touches on another important aspect of the cleaners' perception of their cleaning work: the idea of cleaning up after others. Dawn notes that, "[Management] will tell you but it's your job to clean after [patients],

¹³ so [translated]

but we know it's actually not". The cleaners I spoke to tended to agree, they felt that their jobs often involve cleaning up after others, what Dawn likens to the idea of being a "servant", despite this not being their actual role:

With the patient you can't actually, you must just, we know we not there to clean after them but it's our job unfortunately, we have to.
[Dawn]

Sometimes they just, how can I say now, sometimes they just so disgusting. Like they adults but they like keep them like children. Like, they will like throw something on the floor all that. Even...fine I can understand if it's the patient who had a C-section, who's in pain or someone who just gave birth, but sometimes... like there's an antenatal place, there they just mess like there's a cleaner to clean up... I don't like that. Fine, it's in my job description and I must maar just do it. [Crystal¹⁴]

If someone is walking over a wet floor, there's a wet sign, she see you mopping or he see you mopping there but they do it. It's just like: 'We don't care about you because you doing'... where they put dirt, you pick it up so they think it's usual so they must be like that. [Stacey]

You get that people, like I'm saying they say its almost like you're a cleaner, your there to clean up after me, then they just, they wanna do what they wanna do. Its like... they just aspris¹⁵ there to mess their drinks because it happened to one of the other girls. This, I didn't know what she said, but so with the patients husband, visitor or whatever, they threw a drink against the wall. So she had to clean it up, he did it on purpose. [Crystal]

Location, Location, Location

Working in the Hospital

To the cleaners I spoke to, the hospital is a very specific work environment that carries a particular meaning. From the conversation around the role of cleaners in this space, it is clear that these cleaners feel that they play a part in the overall purpose of the hospital. Just as Bello *et al.* (2009) noted, cleaning appears to carry more weight in the hospital context and being a cleaner in the space is

¹⁴ All quotes from Crystal are taken from interviews conducted on the 31 October 2012 and the 3 January 2013.

¹⁵ do it on purpose [translated]

perceived as more difficult than being a cleaner in other spaces. In light of the types of things one sees in the hospital and the type of things one needs to clean (vomit, urine, faeces, blood etc.), cleaning here is understood as something that involves heightened experiences and as something that not everyone can do.

The distinctiveness of hospital cleaning is apparent in that there are specific rules that need to be followed and “there’s things that you must be careful of and things that you must do.” [Joyce]. The increased importance of health and safety in this healthcare space is evident to cleaners. The hospital is also a unique work environment because of the patients (Salerno *et al.*; Ashforth & Kreiner, 1999). For Susan this was the main difference from other cleaning work. She emphasised two aspects of working with patients that makes cleaning in the hospital unique. Firstly, cleaners engage with people who have a variety of illnesses and secondly, cleaners need to be able to communicate with patients as these are the hospital’s clients.

Similar to the above, the cleaners generally described the hospital space as one a cleaner needs to get used to working in. This idea was specifically related to the variety of experiences a cleaner is faced with in the hospital as well as the number of things one needs to clean. To highlight this, Susan describes the experience of a female cleaner new to the hospital she works in:

There was a cleaner starting to work there then she was getting naar¹⁶ every time she said she can’t work like that. Then I say then you must go to the office because she says she can’t work with sluice, the po-po and that and then I say this is a hospital, you are going to work with that. There is not other things that you are going to work with. So then she said no this, she is going to try to go and speak to the supervisor. Then I dunno what happened. I think she is working day shift, but she’s working I dunno where. It’s not every body that can work with this kind of thing. You see... if you going to clean a vomit, you also get naar, now you not gonna end up cleaning there. You get people like that. Then you get people who’s used to it. You can, you just clean it.

¹⁶ nauseous [translated]

The word 'strong' was used by some of the cleaners to describe the type of person you need to be in order to work as a hospital cleaner:

Then only thing I can say is that you need to be strong. If you are not a strong person, then the hospital work is not for you. Then I don't know what kind of work can you do if you aren't. But you need to be strong. If you are not strong then I dunno. [Susan]

If I get into a ward with very sick people I must, the only thing I have to do to myself is to tell myself that I must be strong enough because each ward you get in there are different sickness, people with different sicknesses so if you get into your ward you have to be brave enough in that ward so that you have to, you won't, if you see that sick person, those sick people, they won't disturb you from doing your job. So you have to be brave enough. [Glenda¹⁷]

From my conversations with these cleaners it was emphasised that not everyone can do this work. In this way, these cleaners seem to give themselves some personal validation and praise for being able to work in the hospital environment. Within this context, however, they find themselves with a specific status, which mediates their experiences. And because of it, they do not seem able to enjoy or value working in this space, or the character they exhibit by being able to.

"Unfortunately [I work for] a private company"¹⁸

Cleaners have a specific status in the hospital context: low, peripheral, non-essential and invisible (Cohen, 2006; Herod & Aguiar, 2006). This is the reality for these public hospital cleaners. This seems to be exacerbated for private company cleaners who find themselves with an even lower status in the hospital than other cleaners i.e. those employed by the government. Their private company cleaning status is essential to understanding their experiences in the hospital. I asked the cleaners about the tender system and their perception of the

¹⁷ All quotes from Glenda are taken from an interview conducted on the 17 November 2012.

¹⁸ Marion. All quotes from Marion are taken from an interview conducted on the 14 October 2012.

organisational hierarchy in the hospital. Their comments give us a perspective from which to interpret and understand their experiences.

Crystal describes part of the tender process:

A tender.... then a lot of companies like Pronto, say Super Care you know all those small private companies they will come, look around and they will make an offer to the managers and say what they can do better than the other companies. And they will just look through stuff like that and they will decide.

The contract generally lasts for a year or two where a company is 'given a chance', but these contracts are often renewed so companies service the same hospital for a number of years. If a new company does take over the contract, a portion of the cleaners transfer to the new company and some find themselves out of work as the new company brings their own workers. The cleaner who maintains their job may, however, revert back to being a casual worker, working on a casual basis if they are needed. In this way a cleaner can be at the hospital for many years, but as an employee of different cleaning companies. Also, if a contract is not renewed at a specific hospital, cleaners may still be retained by the company and sent to other locations where the company has active contracts. As a case in point, Joyce describes her history with the company she works for:

I first used to work by Groote Schuur for the same boss. And then they need people there by UWC Mitchell's Plain that medical hospital. I went there. Then after that the boss lose the contract there and they send us to Somerset. That's' how I come here. They send us all there.

Once a private cleaning company receives the tender, the hospital pays them per person on the floor. While perhaps not accurately, Stacey points to the fact that the cleaners' pay is only a portion of their actual value to the cleaning company: "...we maybe only get two per cent or three per cent of that salary they pay the government, the government pay the cleaning company." Unsurprisingly then, as was described by Zuberi and Ptaschnick (2011), Davies (2010) and Tregenna

(2009), the private company cleaners earn less than the government cleaners and government cleaners also get other benefits: “you get housing, you get medical, clothing you get by a government cleaner, but as a private cleaner you don’t get that things.” [Stacey]. Some private company cleaners do not get paid more for overtime hours or for working on public holidays.

There is generally some form of probationary period when a cleaner first starts working for the cleaning company: “You start as a casual then after three months they make you permanent.” [Dawn]. During this time, it seems that workers have to sign new contracts each month. However, the idea of permanency is problematic as, depending on the company, cleaners still have to renew their contracts every six to twelve months. As Glenda states, “I can’t say it’s permanent because every time after six months we go and renew it.” Joyce also describes a very different circumstance:

by the company that I’m working, for the year when you start. Like for instance I start today there, then every month you must go sign contract by the office so that is actually you a casual. And after two or three years then you don’t need, like me, I don’t go sign contract anymore. So you a permanent now. Say after two, three years you a permanent.

This raises the issue of job insecurity, which will be discussed in the next chapter.

The Hospital Hierarchy

The process and system outlined above feeds into the hospital hierarchy. As I mentioned earlier, the private company cleaners are defined specifically as such, as *private company* cleaners. As a result of this, they find themselves located in a very specific part of the hospital hierarchy. I asked the cleaners to give me a general sense of how they perceived the hospital is organised hierarchically. While not really part of the organisational hierarchy, patients, as the clients, were seen as important to the functioning of the hospital, and as the reason why the hospital is open. They were identified as located at the top or somewhere

near the middle of the organisational ladder. Most of the cleaners identified hospital management and CEOs at the top of the organisational ladder. Doctors and medical students came next followed by nursing staff. In line with Cohen (2006), cleaning staff were generally mentioned as occupying the lowest rung of the ladder.

Importantly, the lowest position was not given to cleaners because they believed that is where cleaners should be located. Cleaners feel that their role in the hospital is important and that they should be considered as occupying a higher position in the hospital:

[Cleaners are] supposed to be also there you see they are important also. Not only the doctors and the nurses or sisters. Even the cleaners also important. They supposed to be on the same level. All supposed to be on top. [Susan]

Similarly, Susan also points out that her description of the hospital hierarchy is only her understanding of where *others* see her and her fellow cleaners: “I dunno why I say that, but that is maybe where they are going to place the cleaners. It will be right at the bottom.”

While all cleaning staff are theoretically at the bottom of the hospital hierarchy, this rung of the ladder is further hierarchically stratified. Most significant is the distinction between employees of the government and employees of a private cleaning company. The diagram below (Figure 1) shows the general ‘chain of command’ in terms of cleaning work at the hospital according to the two categories.

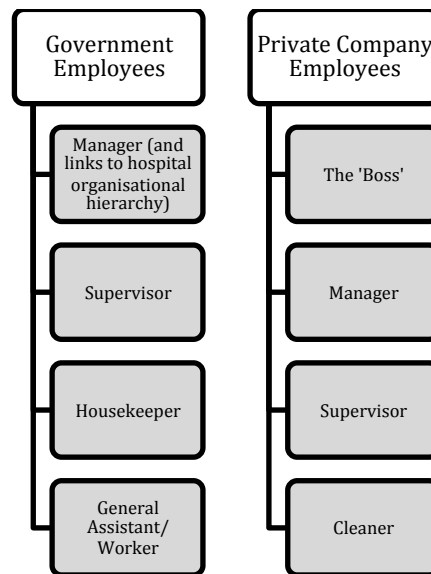


Figure 1: Diagram of the public hospital cleaning 'chain of command'.

Importantly, the general assistants (GA) working for the government are technically viewed as at the same level as the private company cleaners. However, this does not translate over into the workplace. Private company cleaners are comfortable with the idea of any housekeeper or supervisor instructing them, but sometimes the GAs also attempt to tell them what to do: "the GAs and the housekeepers tell us what to do" [Shakira]. This is problematic for the cleaners. As Glenda says, "I don't want to be controlled by someone who is also a cleaner, rather I need to be controlled by the supervisor or the housekeeper."

The consensus amongst the cleaners I spoke to is that they are at the same level as the GAs. However, the GAs, "think we under them" [Crystal]. Joyce describes, "...the government cleaners are not in charge of us. We are at the same level, it's just that they are government and we are [private] that's all. But they think they are in charge of us. Shakira sums up the thinking about the hospital hierarchy:

That's why I say there we are last you see. It's not what we say, it's what they say. It's like that there because we are the contract workers, we are [privates] and they are the government workers they can tell us.

It is apparent how important their identification (especially by others) as private company cleaners is to these women's experiences. Despite my initial perception that the workplace would be most divided along the lines of professional staff and non-professional staff (Cohen, 2006), the divide between cleaners employed by the government and those employed by private cleaning companies was especially meaningful in terms of understanding their experiences. This will be dealt with further below.

***"There is a lot of ways to get hurt at work."*¹⁹: Exploring Health and Safety**

Physical Wellbeing

In line with what has been described by authors (Herod & Aguiar, 2006; Woods & Buckle, 2006; Messing *et al.*, 1998), many of the women I spoke to identified being tired at the end of the working day. Mopping, sweeping and constantly walking up and down are some of the physical activities cleaners' bodies need to endure. There were complaints about sore hands and legs, back pain, swollen feet and nausea. Stacey for one says, "You feel tired because... sometimes you work with machines, you put sealer on, you scrub with big machines so sometimes it affect in your back, your arms..." Glenda points out that the buffing machine is particularly tiring: "the machine makes me tired at the end of the day". Joyce agrees:

I can feel...you know the buff machine man. If I use the buff machine, when I sleep at night my body is aching really. That's why I say I don't know how long I'm gonna dinges with this cleaning business but I can feel my body is not the same. Even my feet is swollen up.

Not only are the physical tasks potentially harmful, but in line with Bello *et al.*, Arif *et al.* and Zock (2005), so too are the chemicals used by cleaners. Both Joyce and Susan mentioned the chemicals they use as potentially dangerous, especially to inhale.

¹⁹ Susan

These cleaners also have to deal with contextual safety hazards beyond the scope of their physical tasks and equipment. Working in a hospital means exposure to a number of physical health hazards. Marion describes the context as “very dangerous”. And the fact that cleaners wear protective clothing such as aprons and gloves and sometimes boots, masks or even full theatre scrubs, shows that the health threat is, to some extent, believed to be a reality. Being in contact with blood and needles means there is a constant risk of contracting diseases such as HIV. Crystal notes that cleaners, including herself, often get needle pricks. Germs are a continuous hazard, but other diseases that were specifically mentioned as potentially contractible were Tuberculosis and Hepatitis. Shakira speaks to this:

Sometimes you make a mistake or something then maybe you work with the needles or something. You got your gloves on and when you taking that thing maybe and that needle can prick you on your finger and then you can get that disease... It's like sometimes you can get that illness. Or someone that cough and has TB and you go in that room...then you can get that. So it can affect us also.

Fortunately, none of the cleaners I spoke to have contracted any of these diseases. Dawn, however, identifies that working in the hospital can exacerbate one's sickness: “maybe you got the flu already, but if you work there then it gets worse and you don't get healed quick.”

The insecure nature of their employment, and heavy workload suggest that cleaners may not comply with health and safety protocol (Dachapalli & Parumasur, 2012), but this does not seem to be the case. While cleaners make every effort to be careful in their work environments, others in the hospital setting can also put them at risk. Sometimes nurses who are moonlighting dispose of needles or blades incorrectly, and cleaners have been cut and pricked as a result. Even regular nurses have been guilty of this. Needles are sometimes found in incorrect containers, in plastic bags or even in the patient's bedding. In Joyce's case a doctor left a needle in a basin and she pricked herself. She points out that, “you know this doctors they are sometimes so careless man.”

The reality is that other cleaners could also be careless and put another's health in danger. For my interviewees, the main threat posed by other cleaners, however, was through violence. During strikes, unionised cleaners or those employed by the hospital take offence with the fact that private company cleaners go to work. So, "If the people (striking workers) saw us... with the uniform they can hurt us." Joyce elaborates on this threat:

if you don't strike they get angry. And this girl was working on ground floor and she didn't know this people...coming in here was from the strikers and they come to her with a sjambok²⁰ and they told her, 'You, I'm going to get you outside. We waiting for you. We know your face'... That's why I say you can quickly be a... victim of stuff like that.

The public and patients can also be health hazards for cleaners, and not simply because the latter are sick. Stacey mentions that when cleaning passages alone in a big hospital, "sometimes you are not safe". The public is seen as potentially dangerous, because you are not always aware if they are a legitimate visitor or not. In terms of actual visitors, they are sometimes drunk, violent or verbally abusive. As Shakira hauntingly says, "If they want to hit you, they hit you". Crystal recalled an incident where a cleaner said something that must have irritated a patient's partner because, "he started to get violent and he threw the drink on the wall and told her... she must clean."

Patients also get violent and abusive with cleaners. Susan described an instance when a patient threw, "that urine container where you pee in, he was throwing one of the cleaners with that." He was believed to be mentally disturbed. She also mentioned an incident where she tried to help a patient move his wheelchair and he had pushed her to the ground.

²⁰ whip [translated]

Psychosocial Wellbeing

During her interview, Susan said that,

you need to be strong and you... need to say to yourself you must be ready for a lot of things that can happen... Like I say there is a lot of things can come your way, you must be ready and you must be handle situations like that.

This quote can apply to the physical health and safety challenges faced by these staff members, but also to the psychosocial challenges. The hospital context is a very particular psychosocial environment that can have many negative effects on a worker's mental wellbeing (Woods & Buckle, 2006; Søgaaard *et al.*, 2006). Some of the cleaners acknowledged that they had never really thought about the psychosocial effects of their work, but they believed that it did indeed have an effect. Joyce describes how she feels her work affects her:

I can't explain to you... but it have an effect on my mind... You see, like matron is telling you you must do this, sister is telling you you must do this, supervisor is telling you you must do this. Now the patients call you at the same time you must...it's like you can't remember everything you must do... It's affecting my mind because I must do a lot of things at once you see. It's affecting. When you come at home, you see, you got problems at home mos sometimes. Work, and home it's...it's too much sometimes. So I can say it's affecting my mind.

The layers of authority that these cleaners have to deal with can clearly be straining. A number of emotions are also triggered as a result of work. Cleaners felt angry when others did not clean up after themselves or were disrespectful: "it just make me angry because when there is a bin why must you throw the stuff on the floor?" [Crystal].

Additionally, The word 'stress' came up a number of times in conversation with these cleaning staff. Stress was said to be the result of dealing with others (visitors, nurses and cleaners employed by the hospital), heavy workload,

flexible hours (which dictates pay) and, most pertinently, the fact that people do not appreciate their work.

Sadness or unhappiness was also mentioned. For example, Joyce says that, “sometimes you feel like crying” and Stacey says that, “sometimes you start crying.” Glenda mentioned that working conditions and the way in which cleaners are spoken to are some of the reasons why they may be sad at work. Dawn also elaborates on why this may be:

Maybe some people are not happy in their job. Or maybe they got a quarrel with the manager or the supervisor or sometimes the patients don't cooperate with you if maybe you've cleaned that place already and you know its clean and they just leave their things there and you must pick it up. Now you have a tiff with a patient and that now maybe it's this stuff that makes you at the end of the day unhappy or unhappy in your job.

Another factor that affects psychosocial wellbeing that is especially pertinent is emotional labour.

Emotional Labour

Emotional labour has been shown to have negative effects on workers (Erickson & Ritter, 2001; Ashforth & Humphrey, 1993). These cleaners are required to perform emotional labour in the way that they suppress their true emotions. Glenda says this very plainly: “we are not supposed to be sad at work. If you go to work you must feel happy, but because of some conditions that's why sometimes they feels sad”. In this statement Glenda points out that despite the unhappiness that a cleaner may actually feel, this is not what the organisation requires of them and instead, their disposition needs to be pleasant. Marion describes the ‘ideal’ disposition:

Thing is, we must make... we must always be happy. You must smile, we mustn't go out with a long face or say no, I don't want to talk to them. No, it's not like that, you must be happy every day.

Cleaners are also faced with another form of emotional labour; they engage meaningfully with patients. This is emotional labour because, as Hochschild (2003) describes, these interactions are controlled; cleaners are obligated to be polite to patients. The notion of obtaining a desired psychological state in the patient as client (Hanser, 2012) also exists. However, patients also turn to cleaners for emotional support in the hospital context and this extends the nature of their emotional labour. As Wharton (2009) highlights, caregiving is a very specific type of emotional labour. Cleaners describe their interactions with patients below. It is interesting to note how patients are thought to see cleaners as more approachable than nurses or doctors. Therefore, they tend to take on the role of visitor for the patient because they “need someone to talk to” [Joyce]:

It's true because when...the patient are just people like me. They are people just like me. So, there is nothing wrong to talk with that patient because if she feel like talking to you, you have to answer. So that she will feel refreshed and... sometimes if you talk to her your answer will make her feel... relieved or feel better by answering her...You don't know, maybe your answer will be nice to that patient. [Glenda]

They say, '...Wow! I'm lying in hospital. No one is visiting me'. Then you are there to speak to them and say, 'Oh, don't worry man. You just here and think of your illness. Just relax, don't stress. They will come or isn't there a number that I can phone them?' Sometimes you always there as a visitor for the patients, that is true. [Shakira]

Because there no family, no friends come visit. Then he just lay there, he got nothing there. Then he just lay on there, talk with nothing. Then you go give his water, ask if he want something; 'Anything you need you can call us and then we can bring it to you'. [Marion]

I think the... patients can make it easier up, hulle kan beter met 'n cleaner praat. Kyk ons is mos nou plat op die grond²¹. I don't know why, maar hulle sal lievers vir jou kies om met te praat²² ... but shame, that's why I like to talk to this patients, shame some of them they are really lonely. People don't treat them well because they are disables, they can't do anything for themselves. [Joyce]

²¹ they can communicate better with a cleaner. Look, we are more approachable. [translated]

²² they will rather choose to talk to you. [translated]

Just greet them in the morning when you saw them and just ask how are you like when you pass then you talk with somebody. Even when you lay on the bed you just talk with them and ask how are you, okay then you just say you mustn't worry and what what. So you just talk with them basically. Because why I think if you talk with a person then you will be fine. Some people come with that, 'What will the doctor say today?' you see. You talk and you say, 'No, you don't have to worry. Don't stress yourself. Everything will be fine' ... [Stacey]

Emotional labour, as the work involved in dealing with someone else's feelings (James, 1989) is apparent. Correspondingly, being a comfort to someone, and listening to them is tiring labour that can have negative effects on workers. This is especially true because, as noted by others (Hochschild, 2003; James, 1989), this comfort and support must take place, but is invisible, unrewarded and not viewed as a source of stress by these workers' employers.

Cleaners also need to deal with loss and pain. They form connections with, and grow accustomed to, patients who sometimes suffer or pass away. They also see others suffer pain or loss, which is an emotional experience:

Like... when they are crying sometimes I just feel the pain, I just feel, I just my tears coming out because they, almost everyone will be crying for that person that is died. [Glenda]

And this one guy ... he was in an accident. He was in an accident come to Orthopaedics... it's all over bandages his legs was and his... he was crying because... the sister says they break his legs right. He was screaming there it was so... It's like I feel his pain. [Joyce]

There is also the acknowledgement on the part of cleaners that "there is nothing you can do you". Their lack of power to influence patient outcomes can lead to feelings of guilt and helplessness (Raphael *et al.*, 1996).

Experiencing traumatic events is particularly a struggle for these cleaners. In line with Hochschild's concerns (2003), private companies do not have coping mechanisms in place for the hospital-specific work experiences of cleaners, especially in terms of emotional encounters. They do not acknowledge this emotional labour as a job stress, or even as part of the job at all. It was only

Crystal who mentioned being able to visit a social worker if she asked and was granted permission. She also mentions the type of instance where emotional and psychological support is actively provided:

Something happened there, but it was on a Friday. Fine, they keep everything under wraps. A lady did jump out of the window. ... she took her own life. So they gave... I know the people went for counseling and all that. Everyone who saw it and that they went for counselling...

It was only in this 'extreme' case that cleaners were encouraged to seek coping support. Yet witnessing the deaths of patients in other ways is not deemed necessary of active intervention.

Similarly, as Mason and Chandley (1999) note, these cleaners have very few ways in which they can possibly respond to depression, anxiety, anger, frustration or powerlessness. Usually, feelings are simply bottled up. Particularly when faced with verbal abuse or disrespect from the patient as the 'sovereign customer' (Nixon, 2009), the general response is to "just move on" [Crystal]. Dawn explains why she adopts this type of response: "I will leave them ... because at the end of the day they can report you and the thing is this, like they say in the shop 'the customer is always right', now here is the same thing. ... they won't take your side as a worker."

Prevention? Health and Safety Training and Precautions

The physical and psychosocial hazards that form part of everyday working life for these cleaners are apparent. The importance of health and safety is therefore undeniable. Even popular understanding of the hospital context would likely highlight the space as one in which health and safety is essential and take on a specific meaning. However, as touched on above, these workers' employers do not recognise them as facing the same risks as other staff in the space. The lack of health and safety coverage in the hospital as a healthcare context was quite jarring.

When asked about health and safety training, seven of these cleaners identified having one day of training. It was only Glenda who said that training was one or two weeks long. Probing further, however, it was clear that all the cleaners' training was not only minimal, but still largely focused on how to clean the various parts of the hospital (wards, offices, bathrooms), not necessarily on health and safety. Cleaners describe the nature of their training:

every Tuesday ... there's a training ... for like the new cleaners that must coming there. So they train you how do you use the gloves or what they using gloves, which colour gloves you must use and like which colour bin you must use and the boxes must get all the blood stuff and like the needles there is a yellow container that you are using for the needles and then it's... the normal dustbin for the papers and stuff. So they are telling you these things. [Shakira]

They show how to clean the blood.... there's some kind of a mop you use and a bucket, like...how many mops you use. The white mop is for the kitchen and it's the white bucket you... using. The red and the red emmer is for the toilet. And the blue bucket is for the passage and the yellow one is for the wards. Then you use that bucket for the wards for the blood. And your gloves. [Marion]

that's where health and safety comes in. You write a test for that stuff so we know what to do. Like you must never just leave equipment because then next person can just come and trip over the stuff. You must always like, if you go to lunch, we've got these small rooms where we've got all our equipment and everything... you can't just leave it just so. [Crystal]

Susan highlights something particularly troubling:

Training...to tell you the truth I never actually get training, training that I can say I go to training. But the day shift people that go for in-service training, they do go and then they hand over to us and they tell us what happened. But I can't say that I have went actually for training.

She continues,

The supervisor that was working night shift that time was showing me the ropes. Because of her she was actually... I can say she was training me how to work with the machines, how to do this, how to do that.

There is clearly a difference between the training given to cleaners on the day and night shifts, which is problematic because health and safety hazards do not disappear for those who work at night. Also, particularly troubling is the fact that Susan's training as a supervisor was also only someone working with her 'showing her the ropes'. Susan's capability and ability to complete her job is not in question. What needs to be critiqued are the means in place through which these women can acquire the necessary health and safety skills.

Also, in light of the hazards these workers face, training seems incomprehensive. It does not cover the range of circumstances and situations a cleaner may face on a daily basis. Their personal wellbeing does not seem to be accounted for in training. Cleaners are not informed about how to prevent or deal with the concerns that they actually have: back pain, sore feet, fatigue and so on.

Some preventative measures are in place to protect workers (gloves, boots, goggles and in Marion and Crystal's cases an injection). However, in other ways, 'protection' is only curative. Cleaners identified that if they get injured on the job (and it is not their fault), they can get the necessary treatment, mostly in the form of injections. That some cleaners are not given injections in order to prevent disease contraction speaks to the fact that their employers fail to see them (or prefer not to see them) as facing the same hazards as other workers in the hospital. Joyce speaks to this problem when she comments on an injection that is said to protect against germs and sicknesses:

And they don't give us the cleaners [the injection]... I don't know why because we cleaning the hospital that is what I want to know. Why don't they give us the cleaners, never mind if we are contract cleaners, why don't they give us you see that injection they giving in the hospital... They say that injection is... the injection beskerm jou teen ...siektes dat jy nie siek raak nie en soes dy germs an daai²³... So the hospital staff get it. Even the GAs get it once a year that injection, but they say we can't because we contract cleaners. Now our boss, she don't, it's like she don't worry. She don't come to give us that

²³ protects you from illnesses so that you don't get sick and germs etc.
[translated]

injection. Now I think it's unfair because we are also cleaning in the hospital. Why can't we have that injection?

In Shakira's case, this type of injection is identified as necessary, but arguably because of a lack of real concern on the part of her employer, she still has not received the injection:

sometimes it's very dangerous...but we do get injections but I never had one. One day our boss did have a meeting with us, she ask us who didn't have the injection yet. So we lift our hands up but she never come back to us and tell us okay you must take the injection now. I never had the injection.

Summary

Private company cleaners fulfil many roles (both assigned and unassigned) in the hospital. These are arguably invaluable to the functioning of the space. However, what appears to be similar across these assigned and unassigned roles is their lack of recognition and the perception that cleaners are in fact peripheral to the functioning of the hospital space. The hospital space itself is clearly unique, and one in which workers face a distinctive set of challenges, especially in terms of their health and safety. The problem for these cleaners is that they are not recognised as having to face these challenges, which makes them even more vulnerable.

Chapter 6: Deep Cleaning: Unpacking and Understanding the Challenges of Cleaners' Working Lives

The previous chapter raised some of the challenges faced by private company cleaners as they navigate their work in the hospital. More challenges are explored in this chapter. What is evident is that they face alienating work conditions, the features of which are elaborated here. Also, the influence of their labour market status is dealt with. Through our conversations, these cleaners confirmed their position as part of the working poor as well as in jobs characterised by insecurity. I explore the implications of these locations. The chapter culminates with the cleaners' perceptions of their role in the hospital as outsourced but invaluable.

Alienating Work

To start, for these workers labour is not pleasurable, rewarding or fulfilling. As evidence of this, Crystal describes her work as "just a job" and Dawn says, "I just know it's my job and I'm just doing it because it's my work." When describing what her work gives her, Marion only mentions its basic monetary value: "It give me money. It give me overtime sometimes if I ask overtime". Stacey thinks even less of her work's value to her: "Like when, the end of the day when I'm finished there... I get nothing at the cleaning company I get nothing out you see so I dunno what is the use then you work at a cleaning company."

In line with the above, and the lack of satisfaction this work is giving these women, alienating work is work done only out of necessity and in order to survive (Marx, 1844). Joyce says very plainly, "I have to work to survive." And Glenda says that, "If they lose their jobs...they won't have anything to survive". These women identify the fact that they (and others) work because they need to, not because they want to; they work in order to live. The fact that work is necessary for survival means that it takes control of the cleaners' lives (Novack, 1973). The alienating nature of work is also apparent in the way that it is forced and not voluntary. Demonstrating this, Susan mentions that the only reason why

people 'stick it out' is "Because there is no other choice." Glenda also says that, "there is no option... No matter you are satisfied".

This force is also exerted through punishment or threat thereof. These cleaners continue to work and complete work tasks in order to avoid negative repercussions; in order to stay out of trouble and to keep their job. Crystal describes that sometimes she does not feel up for coming to work because her body is tired, but that, "I have to come because I don't wanna go in a hearing or sign a warning or such stuff... I just come." This is in line with the work of Stinson *et al.* (2005) who note that fear of being dismissed means that workers often come to work ill or in pain. On-the-job activity is also produced through fear. Susan says: "at the end of the day you don't want trouble so you do all the work" because you "don't want any reports going to the matrons office". Similarly, simply appearing to be actively working is important, Marion says, "you must have something in your hand like a lap. If the supervisor catch you with nothing in your hands then [there is] big trouble."

Under alienating conditions it is believed that only a fraction of the workers' ability and intelligence are necessary for them to complete a task (Erikson, 1985; Mottaz, 1981). While cleaning work is characterised as a low-skill occupation, it has become obvious that this is not the case. Cleaners actually do a lot and "work... harder than any other person" [Joyce]. Alienation may not arise from the fact that workers do not utilise their skills, but rather from the belief of others that their work requires limited ability and minimal rewards; there is a lack of recognition of the skills and capacity necessary to complete their work. How these cleaners are treated and what they are given in return for their labour is alienating. This happens through the manner in which the low-skill and hence low rewards system is perpetuated.

The cleaners describe this treatment: "They think because you are a cleaner you are stupid and the way they mess is the way [they] say it" [Susan]. Similarly, "they think cleaners are not educated people... they are learned and what what so they think us cleaners maybe we... we don't have any qualifications in terms

of education so that's why some of them they treat us like that" [Glenda]. Joyce speaks to the alienating nature of rewards:

I don't know why we getting paid like that... never mind most of us is not ... people with grades and that and we didn't make matric or whatever ... but I mean you not stupid, but why must they give us money like that? I mean it's ridiculous.

What these cleaners appear to believe is that, "even [though] our pay is little, they must regard us as very, very important people" [Glenda]. This, however, is not the case, and is mostly the complete opposite.

People desire to be social, sociable, creative and to do work that is stimulating and useful (Reiss, 1997). These workers are not given the opportunity to do this type of work. Or, when they do useful work, they are not made to feel that they are. While ideally workers should feel that their work is valuable and meaningful, instead they are alienated, "Because most of the time they don't let you feel like you important" [Dawn]. Joyce has a similar feeling. She says that, "people don't appreciate what you doing". The idea of gratitude and appreciation are important to these women as means to achieving validation: "if someone does that, they say thank you for what you are doing, you feel good" [Crystal], "that will make you happy" [Susan]. The reality is that people "don't say thank you, nothing" [Crystal] and Susan wishes they would "just say thank you for a change and stop complaining".

These cleaners do not have control over the products of their labour. Cleaners take pride in the clean spaces they produce, but are unable to control what happens to them. They feel like 'nothing' as a result of the disregard for the product of their labour and their inability to control what happens to it:

They don't care because if you are mopping there some of the doctors or the visitors... just don't care. They will just walk over that wet floor with their dirty shoes and you must just go mop there again you see. So some people think nothing of us... [Dawn]

It's like we are nothing in hospitals. Sometimes other people... just walk over your floors no matter if there is a wet sign they just walk. Like you can do it again. You do it now so you can go back and do it again. It's like that. They think nothing of you. [Stacey]

You know what they do sometimes if you clean the room, that problem I had, many cleaners complain about that, after you are cleaning your ward... they just throw [rubbish] on the floor so that the cleaner must come again and pick that here... and it's not good... [Glenda]

The most stressful part is that people don't appreciate what you doing and I hate it when people walk over my floor when I'm mopping you see. There is a wet sign but... they walk over your floor you see. It's like they don't have respect for you... [What] I hate in hospitals is people walking over my floors and they don't care... That other man tell me, 'Jy is mos hier om skoon te maak. Waarom moan jy' omdatek gese het van die vloer²⁴... [Joyce]

The alienating reality for cleaners is that the products of their labour belong to someone else. Part of what this means is that they are constantly open to scrutiny. According to Glenda:

...there are those people who complains too much about the cleaners. It's not fair to complain for the cleaner every time. Because the, that cleaner is maybe it's just a small thing of...the, the big thing you have done. Then it's someone can complain that you have not mopped just a drop of blood. Maybe that blood it was there after, you have already finished cleaning.

Susan describes how this feels:

you trying your best to do this ever day in your work. Every day you working, you don't get off, you working. You are helping the people where you can. You are doing the work. You want the work to be done... So, at the end of the day they coming in and they find something wrong, it makes you sick because you know, you as a person you try so what more they want from you, you don't know.

²⁴ 'You are here to clean. Why are you moaning?' Because I spoke about the floor [translated]

Similarly, Joyce says,

But you know this public is very... they are the people that complain, always complain about the toilets and so on. And they don't want, they want to be rude to you then they first run to the complaint lady, Sister Philander and they complain... And who's the one they blame, they blame the cleaner... always if there is something wrong they gonna blame the contract worker.

This speaks to another challenge faced by these cleaners, while they lack control of their products, they are also the ones reprimanded if something is wrong. Again, the idea that cleaners are only visible when something goes wrong is evident.

For Marx, alienation is evident in the way that relationships between people are mediated under capitalism (Grant, 2011). Crystal describes the hospital as the “client” of the cleaning company. Similarly, the doctors, clerks and patients are seen as clients who need to be treated in a specific way: “...if we don't keep the client happy then they can just let us go like now.” The relationship between cleaners and these parties is simply contractual and hierarchical.

For Ollman (1971), an expression of alienating labour is the fact that mutually beneficial relationships with others are not possible. Stacey describes the threat workers can pose to one another. Her comments show how relationships are not supportive or encouraging:

Like colleagues, people that hate you, people that don't like you all those kinds of things can happen as a cleaner if they don't like you... people they can do anything, make you lose your job... They can go behind your back, talk that you do that and that. People can put chemicals in your bag... if they maybe searching bags they can put chemicals because of that you can also lose your job.

Due to competition people are estranged from one another (Grant, 2011). The idea of competition that capitalism instils in workers is marked here; there is a desire to be recognised above another (Woodfin & Zarate, 2009). It appears that

only by having someone below you, can you have some kind of status yourself. Shakira's experience can be seen as evidence of this:

Okay, it's like almost like umm... you see, sometimes one person just want to take over a place. It's almost like they want to be like a boss or something you see. So I think it's like that. We were coming there, but they were throwing that in our faces, but we must do the dirty work you see. Every time when there is something like shit on the floor or pee or someone did vomit they just say hey, you must come and clean here. They want to choose what they want to do. They are like that. So I think that is the thing, they just want to be like the bosses there now they throw that in our faces. Everyone must know that they are high and we are low. You see the people is mos like that.

Government workers may see private company cleaners as a threat to their employment security. To some extent, private company cleaners have replaced some of the government cleaners in public sector hospitals. To these cleaners, however, they are a threat to government workers in a different way. Government cleaners are seen as only doing light work: "they don't clean, clean" [Crystal]. Similarly, Stacey describes how a private cleaner becoming a government cleaner would be threatening to those already in that position and why the former private cleaner would be treated badly:

because why they know you know what is cleaning because why government cleaners they don't scrub, they don't polish, they don't deep clean. As a private company you do that things for the government workers. So, if you start for the first time as a government cleaner and you was by a private company cleaning then they will treat you like that.

Meaningful and useful work is also stifled in terms of social interactions. The fact that these cleaners perform emotional labour, and that positive interaction with patients is encouraging to them should be a source of happiness. However, potentially meaningful interactions are discouraged; the general idea is, "Don't interact with the patients because you here to do your work" [Dawn]. What is worse is that interactions with patients are sometimes turned into something else: a reason for punishment. Dawn explains why she avoids interacting with patients:

like I know our policies we not supposed to sit with them... I never sit down and talk with them because one day our ops manager came in and she got one person talking to a patient and she gave... that girl a warning. And she didn't ask why you talking to the patient, maybe they could have been related, maybe she could have just given her a message to take home. She didn't ask her anything she just said, 'Come down to the office and there's the paper' and she had to sign a warning.

Similarly, Marion points out that relationships with nurses and doctors are also discouraged because the cleaner might, “just want to stand there and... forget about the work by the other side.” The ability to form bonds and see how they fit into the bigger purpose of the hospital is not overtly available to these cleaners. They can be described as isolated in that their relationships with others do not extend beyond their work activity (Twining, 1980). Or at least this is not encouraged.

Work is also alienating when it is stripped of its self-realising qualities (Yuill, 2005). Private company cleaning work does not allow these women self-actualisation. Dawn feels that she “can't be choosy”, so she continues to do cleaning work. However, she intends to study further in the hopes of getting a job in administration. Shakira is also only keeping this job “until [she] finds another job”, saying, “it will be better if I find something else”. These feelings that work is not self-fulfilling are characteristic of the idea of self-estrangement that characterises alienating labour (Mottaz, 1981; Kohn, 1976).

One does begin to question why these workers do not just do something about their work situation. The reality, however, is that alienated workers lack formal rights and positive structures in order to ensure they are protected and have decent working conditions (Yuill, 2005; Schmitt, 1994). The lack of unionisation of these workers is evidence of this. Private cleaning companies are said to not ‘like’ unions and their cleaners are, “not supposed to belong to a union.” [Joyce]. Glenda states that, “if they hear you are in union it's like you fired.” Supporting this, Joyce describes what happened to private company cleaners who attempted to join a union and subsequently why she is not a union member:

There were people there asking us if we don't want to belong to a union and there was people that wants to. But you know what did the boss say, she was so spiteful she take all of them and she send them to a other contract. It was mos there by our hospital that the union... she sent them and the others was losing their jobs. And she warn us, if you want to belong to a union, you can get you a other job. So we not belong to a union.

Due to the above, Joyce goes on to say that, "I don't actually know if we got rights because if you don't belong to a union you don't have rights". What is most disturbing is the fact that, as Mandel (1973) says, under alienating conditions, people give up their rights to institutions that are hostile towards them. However, the hostility of private cleaning companies appears to be more overt because workers are threatened into not joining unions. To demonstrate this, Stacey explains her choice not to join a union: "you just follow. That's to keep your work, you just do what the others does." What other private company cleaners are doing is remaining silent because the potential repercussions are too great: "for us if you complain it means... they take you as someone who can encourage strikes so... maybe you gonna lose the job for that" [Glenda]. This fear of losing one's job speaks to another challenge faced by these cleaners, the issue of job insecurity.

Job Insecurity

In line with the perceived significance of the concept of job insecurity in the contemporary labour market (Dachapalli & Parumasur, 2012; De Witte, 2005; Sverke & Hellgren, 2002), it is undeniably relevant to the working lives of these workers. In light of what is now known about the tender system in particular, working as a cleaner for a private cleaning company is a very insecure form of employment. A number of the characteristics of this type of employment mean that its level of job insecurity increases. If we understand that job insecurity is partly a feeling of uncertainty and awareness of the possibility of being replaced (Van Wyk & Pienaar, 2008), the interviews conducted highlight how pertinent this concept is to the lives of these workers.

As a form of stress, job insecurity involves worrying about the continued existence of one's job as well as features of it (van Wyk & Pienaar, 2008). Both these aspects are apparent in the experiences of these workers. Crystal describes the feeling of potentially losing her job: "It doesn't feel nice because you don't know where you on or off... we don't know who is now in or out." Glenda speaks to the other facet of job insecurity:

there is nothing that stresses me out mostly. Except the number of the days sometimes. You sometimes have just a few days to work because we are paid according to the hours so those hours sometimes you get less hours which gives you less money sometimes that thing, sometimes it stress you.

As a result of their jobs being under threat, the insecurity of these workers increases. The nature of their contracts and the contracts of their employers with hospitals is in a constant state of flux: "after a certain year they change companies" [Dawn]. There is uncertainty around whether or not the cleaner will remain employed. These cleaners are not always able to say that they will have a job next month, but more difficult it seems is the fact that they do not know if their employer will maintain their tender contract. Joyce talks about waiting to see if her boss "survives" the contract. Cleaners are powerless to affect the nature of their employers' contracts and this too increases job insecurity.

Crystal identifies the general worry of losing the contract with the hospital and interestingly uses the pronoun 'we' when referring to her and her cleaning company: "what if it comes we must lose the contract". The worry about the security of their employment extends beyond their performance on the job and their relationship with the company. Their concern extends to the relationship of their company with the contractor and the competition of other companies. As Shakira notes, "the boss she also have a contract you see", which then becomes something the cleaner also worries about. The multiple potential threats to the stability of their employment increases insecurity.

In describing her personal work contract, Dawn gives us a sense of the insecurity of her employment. The word 'permanent' has taken on a new and quite contradictory meaning in the context of private company cleaning work in the hospital. She says, "It's a permanent contract for now... this month and next month. Then the tender is finished." The 'permanency' of these workers' employment is short-lived and is dependent on factors largely beyond their control. Marion also identified the changing meaning of 'permanency'. While she said that, "If you not permanent you can get fired." She simultaneously describes herself as a permanent worker and worries that, "Anytime you can get fired because they like to fire you." The reality for these workers is that their employment is persistently insecure.

As De Witte (2005) points out, job insecurity is not simply about the loss of the job, but also its features such as status and pay. While Crystal recognises that she may still be employed if a new company takes over the hospital's cleaning contract, there is a drop in status that occurs. She would return to being a casual worker, which is associated with more insecurity. As she says, "We as a permanent people we get first preference to the new company...Then they'll take us on a casual basis and if they need more people they'll let you know but then if there's no place then you have to go look for a other job."

In light of the responsibility and pressure to provide for their families and lack of employment prospects, job insecurity is increased (Sverke & Hellgren, 2002). A quote from Stacey sums up their situation: "some have kids maybe two or three kids so they can't get a job really, you can't find a job nowadays you can't get a job like if you want it". This is directly related to the labour market. The high level of unemployment in South Arica increases job insecurity (Lambert & Webster, 2010; De Witte, 2005; Marmot, 1999). Also, the category of work these women fall into is characterised by fewer employment opportunities (Armstrong *et al.*, 2008; De Witte, 2005; Sverke & Hellgren, 2002). The sentiment amongst these women is that, "work is scarce" [Joyce] and "it's not easy to get work" [Stacey]. Marion similarly points out that she does not envision likely employment if she loses her current cleaning job: "I can't lose my job because if I

lose my job there is no job for me.” Glenda links this to why insecurity is rife (why people worry about their jobs):

Most of the people who are in a cleaning job... which are employed in private companies, they don't have proper jobs to do so they worry... if [they] lose their jobs, because... that is the only job for them to do. Maybe they found that job after a long... struggle you see.

Not only is work scarce, labour market expectations have increased in terms of cleaning work. As Stacey points out, “if you don’t have matric it’s difficult...nowadays...they say the basics matric”. Crystal came to this realisation as well: “At first I used to think no its easy because...there’s lots of cleaning jobs around... now everyone is so full...you must do this you must have this its not easy now anymore you cant just get in you must know the people.” These labour market ‘trends’ increase levels of insecurity as finding employment is perceived as more difficult. The highest level of education of seven of the cleaners I spoke with is between Grade 8 and 10. Only Crystal has a Matric certificate. For these cleaners the prospect of losing one’s job and finding employment is increasingly daunting, therefore increasing feelings of insecurity. The labour market also facilitates their experience of working poverty.

Working Poverty

These workers make it clear that their work does not lead them out of poverty. The reality is that their incomes are barely enough to survive. When reflecting on their pay, Stacey says, “You can’t even survive with it really”. Echoing this, Joyce says, “you can’t survive with that money”. Crystal hints at the idea that her income is helping her husband support their household: “at least I’m helping him you know.” Her job is only able to *assist* with the household finances. Due to the nature of their occupations, dual or tri-incomes (either with spouses or parents) were necessary merely to sustain the household. Joyce is a more extreme example. She says, “I’m lucky I don’t have children” because even with her and her husband’s income they struggle to get by. In keeping with the literature on

the working poor, the potential of getting out of poverty or improving living standards seems unlikely (Shipler, 2004).

In line with the findings of Ehrenreich (2001) and Chilman (1991), these women also felt that they were working hard and obeying the rules that should lead to some economic security. However, the idea that hard work leads to success has not been their experience. When commenting on their work, Crystal says, “I just think we do a lot, we do too much for that little money.” Glenda points out the reality she feels they are faced with: “Because the money is sometimes very little... It’s more job and less money.” The frustration and hopelessness that this working poverty leads to, is summed up by Joyce:

It’s just that the money is too little. By the end of the month when you get your money you think for yourself... I’ve worked so hard this month, I scrubbed, I must do this and do that sometimes you must do things that you not supposed to do ... At the end of the day you get your wages you feel so frustrated because you can’t do anything, everything you want to do.

The hopelessness that is associated with low-wage work is manifest in a number of phrases they use. A number of women mentioned the resigned idea that they must ‘just do it’ and asked the question, ‘what can you do?’ Two phrases used by Crystal also stood out to me. She said, “there’s no other way or no other work” and “beggars can’t be choosers”. These are characteristic of the manner in which these cleaners perceive themselves in relation to their jobs. Hopelessness is evident here as they struggle to survive doing work that is their last resort, but also in having a job and working hard, but occupying the position of ‘beggar’.

The economy and labour market play a role in working poverty in general (Shipler, 2004; Chilman, 1991), but seems to be a very central part of these workers’ poverty. As was touched on when discussing job insecurity, most importantly, “work is scarce” [Joyce], which means that workers ‘tolerate’ low-wage work. The notion that these workers ‘chose’ their jobs is given to them as a reason why they should not complain: “the manager told me, she didn’t ask us, she didn’t give this job, we chose it” [Crystal]. The outsourcing of cleaning work

and the competitive tender process also encourages workers' wages to remain low. Joyce highlights how working poverty can be perpetuated as hospitals go for the cheapest option when selecting a private cleaning company: "They pay the lowest by our boss, the lowest fee or something like that. That's why they keep us."

The "constellation of difficulties" that characterise working poverty (Shipler, 2004: 285) are visible in the lives of these workers. Their low wages are 'complemented' by relatively low levels of education, which provide few employment opportunities. Four cleaners mentioned that cleaning work was not a choice. The reasons for doing cleaning work were because no other jobs are available, but also because they are limited as a result of their education. Surviving from pay cheque to pay cheque is accompanied by a lack of employment benefits such as medical, housing and in some cases no annual bonus. Unfortunately, this is also sometimes accompanied by poor spending. Joyce identifies this problem in herself: "I like to make... debt so I must work. I like to make open accounts and stuff so I have to work to survive." She also told me that the last loan her and her husband had made (which was for renovations), had been used to "pay our accounts", so they need to make another loan. Another difficulty that stood out was that of location and travelling to work. All of the workers mentioned travelling, either to work or to their companies' office to sign their contracts, as a burdening expense. Just as Bezuidenhout and Fakier (2006) found, these workers spend R300 – R500 per month on transport, which can be 20% - 30% of their salaries.

The nature of the jobs occupied by the working poor provides little status and little chance for advancement (Chilman, 1991). Visitors, patients, nurses and managers sometimes treat these cleaners in a way that reminds them of the perceived status of the cleaner: "the cleaner is just there to do dirty work" [Joyce]. They treat these cleaners as if "they don't think you have a skin on your face. They embarrass you" [Joyce]. Status is used as a tool to make these workers feel inadequate and inferior. Glenda picks this up in "The way they talk to us, sometimes they talk like they are talking to small children". Similarly,

government cleaners often “throw it in [their] face” [Shakira] the fact they are private company cleaners and must do the “dirty work” [Shakira].

As was elaborated on earlier, the ‘dirty work’ mentioned here is typical of the low-wage work of the working poor; both physically and psychologically damaging (Chilman, 1991). In line with the true nature of low-wage work, cleaning work is not unskilled. It requires the adoption of new skills, use of equipment and occupational knowledge. The cleaning equipment and chemicals used are context-specific. So too are the manner in which cleaning activities are done and the manner in which waste is disposed of in the hospital. For example, the buffing machine requires practice to master and there are different bins for medical waste, needles and so on. The hospital is also its own social world that needs to be navigated. In terms of this, one thing Susan points out is that, “It’s different because we are working with patients. That is the difference. You get all different kinds of people, different kinds of people that’s sick.”

Despite the above, the low wages and lack of recognition, the working poor take pride in their work (Ehrenreich, 2001). This is most definitely the case with these cleaning workers. These cleaners seek to do their jobs to the best of their ability, take pride in the products of their labour and often go beyond their actual job requirements:

in our job description you mustn’t clean people’s dishes like when you doing offices and that you not supposed to clean their dishes and that but we clean the kitchen, we can’t just leave the dishes there because it is going to look like a place is not clean. Now we clean their dishes ... we don’t wanna leave it so because then the place look unfinished. [Dawn]

I’m not even supposed to do, you know what that nurses there... I clean the tearoom, I will do it for them, but they like for instance they just sit and eat... their cups and that they just leave it there then you must clean it and my matron told me, that is not your job, they must clean their own cups and whatever they use. But imagine you, I’m there mostly for the floors and the toilets, imagine you mopping the tearoom and here’s the dishes all standing. So I clean it. [Joyce]

So everyday I go there I check the whole place whether they did clean or whatever. I check the whole place. If it's clean then I feel okay now I can rest. It's almost like that. If I go there it's almost like this is my place. So I check if the bins is clean. I check if the bags that's in the bins is clean. I check if the ward is clean. All the papers is out of the wards like on the cupboards... I check if it's clean then I wash it off. All that kinds of things before I feel like okay, I'm gonna take now my tea time or I'm gonna go now lunch. Everything is sorted out. I'm like that. If one thing is dirty then that thing is bothering me then I just do it and I make it clean. [Shakira]

The manner in which these women take pride in their work touches on how important they believe their work is. This is in stark contrast with the perceptions of members of the 'public, which serves as another challenge for them.

Conflicting Perceptions

Dealing with 'Public' Perception

Joyce notes peoples' reactions when she asks them not to walk on her wet floor. Their response is usually: '*Haai man, it's jou werk wat jy doen*'²⁵. This quote highlights the fact that the public has a different perception of the cleaners' role. As Crystal notes, the public perception can generally be summed up as, "You're a cleaner, if I throw stuff on the floor, you must just pick up or clean after me." Not only are cleaners expected to clean up after others, but this is seen as inherent to their jobs and not as something to complain about. This perceived perception of the cleaner as someone who cleans up after others, is relatively consistent across the cleaners I spoke to.

Those in the hospital space (workers and visitors alike) were perceived as holding very stereotypical views of the hospital cleaners, especially in terms of their educational status. As Abrantes (2012) notes, domestic tasks such as cleaning and cooking are thought to require very little information and knowledge from schooling and training. Therefore, this work is seen as less

²⁵ Hey man, you're doing your job. [translated]

valuable (Abrantes, 2012). This is a reality for these cleaners. Crystal and Dawn mentioned the ideas that people see cleaners as “under them”, as “servants” and as “just cleaners”. The public’s perception of a cleaner’s perceived lack of education was evident:

you get people like that because they think its like you stupid, sorry to say it like that. They think because you are a cleaner you are stupid and the way they mess is the way you say it. Its like you are there so they are just going to mess. And you must just clean. You get people that’s mindsets is like that. [Susan]

Ja²⁶, some of them is like that, ‘You a cleaner, don’t come tell me’. Stuff like that. You know something better than them sometimes. Now you just want to help them and they like, ‘Don’t come tell me. You are a cleaner’. Stuff like that. Because you know something happened. One of the managers there by us she didn’t now know how to go onto her computer. Something was wrong. So one of the cleaners did show her what to do. Like they sometimes think we just cleaners, but we got bigger goals or we do have computer... like we have certificates to prove we computer literate. [Crystal]

Cleaners themselves sometimes display a sense of embarrassment over their work. For example, Joyce is adamant that she will not work as a cleaner in a shopping mall in case people who know her see her:

Mall... I will never do that. No ways. People up and down and here you come with a mop every five minutes. That’s why I’m saying in hospital you can, people, okay there’s patients and what what, but there’s not a lot of people up and down and see you. Now my aunty comes here and she sees me in the mall mopping.

Another stereotype that is often attached to the position of ‘cleaner’ is that of deviance, mostly in terms of stealing (Bezuidenhout & Fakier, 2006; Ehrenreich, 2001). The cleaners I spoke to felt that theft was a problem in the hospital space, and that cleaners were sometimes the perpetrators, but that the labelling of all cleaners as thieves was unwarranted. Cleaners are often blamed if things go missing and are often, “the first person they blame” [Dawn]. Joyce says that this is one of the reasons why it is “not nice to be a cleaner”.

²⁶ Yes [translated]

The 'deviance' of the cleaner extends to other areas: "they always blame the private cleaner when something goes wrong" [Stacey]. This is in line with the view that cleaners only become visible when a problem arises (Herod & Aguiar, 2006; Ehrenreich, 2001). What makes work even more difficult is that by following instructions they can also get into trouble. Under the instruction of her housekeeper, Joyce scrubbed a portion of the floor. Subsequently, a doctor, having been told that she had just scrubbed the floor, slipped on this spot. She was then reprimanded for scrubbing the floor at that particular time, i.e. reprimanded for following the instructions she was given and despite having warned the doctor.

To some extent, cleaners appear to be the scapegoat for 'problems' in the hospital space. And what Joyce shows is that this is common knowledge to those who work in the hospital. After the incident mentioned above, Joyce's supervisor told her that:

but always if there is something wrong they gonna blame the contract worker. You supposed to know they not gonna go to that people, they gonna blame you now. You a contract worker.

In other words, the blaming of private company cleaners is to be expected.

Counter Perceptions

In contrast to the above public perception, and corresponding to the essentiality of cleaning work in the eyes of authors (Herod & Aguiar, 2006; Woods & Buckle, 2006; Ashforth & Kreiner, 1999), cleaners feel that their work has a broader purpose in the running and maintenance of the hospital. Also, while Joyce appears to be somewhat ashamed of being a cleaner (not wanting to work in a mall in case she sees people she knows), this does not overshadow the general perception that the role of a cleaner is central to the functioning of the hospital (Cohen, 2006). Their descriptions of their perceived role in the hospital show that they have high demands of themselves and a belief that their jobs are

particularly important. What also stands out is the fact that they connect the work they do directly to the purpose of the hospital as a space:

The role of the cleaners...The role of the cleaners is to keep the hospital clean, perfectly clean so that we...there are less diseases to the other people who are coming who are not infected. Those people who come to see their patients, they don't... they must feel comfortable when they come to see their patients because the hospital is clean. But then when it's dirty, they don't. You feel the people they are afraid of getting in the, at that hospital because the dirt, they think they get contaminating diseases. So the role of the cleaner is to keep that place clean. [Glenda]

Like I told you, it's like any other job. Never mind if you a cleaner or a manager everything, like... we are also there to help people, keep the place safe, to keep the place safe for the patients and all that stuff. It's not that our job don't count. Our jobs also do count. You know like the doctors is there to save the people and all that stuff but we there to see that some of them don't pick up... you know the dust is... you can get sick of dust and stuff. We there to see that they don't, especially the children, don't get sick of stuff like that. [Crystal]

The main thing is because why, umm...some people is having allergies that's working in the offices or in the wards it's for to protect the children and all that stuff. Because like the dust at hospitals is not the dust that you get at home. This is germs because everyone comes from outside and you don't know where they coming with all that. [Dawn]

This perception of the importance of their role in the hospital appears to translate into cleaners taking a lot of pride in their work. The hospital context, unlike a shopping mall for example, adds meaning to the work they do. In line with the idea that cleaners do more work than their job descriptions, this extra work is often seen to them as important to their overall purpose. Therefore, they do the extra work because of what they feel it means in terms of their perceived role.

Summary

The nature of alienation, working poverty and job insecurity, as they manifest in the experiences of these workers seems to make them increasingly vulnerable in their working lives. The perceptions of others appear to perpetuate these effects as cleaners are often viewed as uneducated, deviant and peripheral to the functioning of the hospital. Despite this, these cleaners are able to articulate their function in relation to the purpose of the hospital and are able to take pride in work they deem invaluable to it.

Chapter 7: Conclusion

Invaluable and Outsourced

Shakira describes an exchange with a man in the hospital who works with computers:

And like, so I tell him I know cleaners is nothing. So he say, you know what...some people think you are nothing, but some think that you are something because like if, I make example...if the doctors want to use that room now or the office or whatever and there is mess, there's papers on the floor it's dirty there. Then for who do they call? They call the cleaner. The cleaner must clean first before they go in. So that means you are important because you must clean. You the cleaner. And because you everywhere in the hospital. If someone comes in they want to know, 'Sorry, where is that ward?' you must say where is that ward. If any things is happen there they just go to the cleaner. The cleaner must know because the cleaner is everywhere. They must check here and there if everything is fine, everything is still clean. So I say okay. So that makes me feel a little bit better you see.

My hope is that this study will help to bring about the type of awareness afforded to Shakira through this moment of understanding. I can say personally that I have been awakened to the stark realities of the work situations of private company cleaners, and have been able to engage more meaningfully with them through theory. Unfortunately, as evidenced by the media accounts that initially peaked my interest in this topic, the necessity of private cleaning staff in the hospital space is only matched by the lack of visibility, respect and rewards they are offered.

Through this research project I set out to answer a number of central questions. I believe the information gained from my interviewees made answering these possible. From these interviews we can see that private cleaning staff perform a host of duties in the hospital. The most obvious task is maintaining cleanliness. In the hospital, the importance of which is undeniable. Glenda knows this too: "being a cleaner, I feel that I am someone who is very important because

everything and everywhere, in everything you do you first have to be clean, everything must be clean". But the work of these women clearly extends well beyond their cleaning duties. The support they offer government cleaners, nurses, doctors and visitors by going beyond their job description (usually with no reward) also assists in the functioning of the hospital space. And most importantly, in light of the fact that the patient is the centre of hospital care, the fact that cleaners offer them emotional support is essential to maintaining a space that comforts (Garrett, 1973).

Proximity to patients links to the persistent health and safety threats faced by these workers. Just because the expectation is for cleaning staff to be invisible, does not mean that they are not susceptible to physical and psychological trauma in the hospital space. In fact, their invisibility makes them more vulnerable because necessary precautionary measures are often not taken to ensure their wellbeing is maintained. Perhaps even more problematic is the fact that the psychosocial wellbeing of these workers is largely ignored. They are not identified as facing any significant psychosocial trauma in their work, or conducting emotional labour as they interact with others in the hospital space. The fact that cleanliness is essential to hospital functioning means that these workers are ensuring the health and safety of others through their work while theirs is neglected. Similarly, they provide necessary emotional labour. Again, their invaluable nature is 'complemented' only by an increasing desire to have them excluded from the hospital team: contracted out, on flexible contracts or occupying different communal spaces.

Though each of these women have unique, subjective experiences, they find themselves in similar work circumstances embedded in particular locations that lead to some commonality of experience. While Marx would contend that describing the working lives of these workers as alienated would be stating the obvious, this is exactly what this project has come to find. Key components of alienation were evident in the experiences of these workers, manifested in interesting ways. Despite performing such essential functions in the hospital space, these workers are alienated in the way they are not allowed to feel

important to, or part of, the key aims of the hospital. Their work is therefore largely unfulfilling to the extent that it only provides them with a means to an end. In light of what work means in the lives of people and the self-realisation that should stem from work, these workers can be seen as alienated.

Cleaners are insecure about the fact that they believe they lack educational qualifications comparable to medical staff. What makes this problematic, however, is the fact that their educational status is used to alienate them. They feel that they are treated as 'stupid' and 'uneducated' and as 'just a cleaner'. This compounds their inability to feel fulfilled in their work and to find meaning in what they are doing. What stands out is the fact that the people who are largely responsible for making them feel inadequate or like 'nothing' are the other cleaners in the space, namely the government cleaners. The manner in which private company cleaners are alienated from government cleaners is a finding that surprised me. Their relationship is one of tension and competition; their alienating social conditions means that they are estranged from one another. As Shakira mentioned, it becomes important to establish who is "high" and who is "low". The private company cleaners are made well aware of the fact that they are 'low'.

Similarly, that these workers form part of the working poor becomes obvious; hard work and long hours are not necessarily equated with the ability to adequately provide for one's family. The extent to which these workers are struggling merely to survive is haunting. Again, their work is by no means simply fulfilling, but only serves to (partly) fulfil other needs. In fact, just as Marx (1844) indicates, the more the worker gives of themselves through their product, the worse off they become. To a degree, job insecurity in the labour market encourages the working poverty of these staff. The lack of alternative employment options and a large reserve labour pool means that these workers are forced to tolerate their working conditions, but are also fearful of complaining or appearing to incite worker opposition.

Future Research

This study identifies a number of issues that could be touched on in future research. For example, the fact that Glenda was the only non-South African citizen in my study (as well as limits of time and space), made it difficult to explore the experience of a 'foreigner' in more detail. Glenda mentioned the fact that she was mistreated because of her nationality. And Joyce also recognised the struggle of foreign nationals. What is noteworthy though is the fact that Joyce says, "my boss is...mostly taking foreigners now." The tension and increased competition this may produce in the workplace is likely to be an interesting avenue to explore. Other potentially interesting participant characteristics to compare would be gender, age, race and number of years working in the health care setting. Working day or night shift, the level of hospital and whether the hospital is public or private are other variables that could be explored.

Researching security workers in the hospital space is also likely to be a rich area of study. Like cleaners, security staff are increasingly being outsourced (Tregenna, 2009). A number of the experiences these women spoke about also included security workers as the victims of verbal abuse, violence and disrespect. They are also located at the lower end of the hospital hierarchy. Dawn mentions both cleaners and security staff as being placed under doctors and nurses in the hospital space. Most interesting, however, is the fact that Crystal places security staff below cleaners in her description of the hospital hierarchy, describing them as "useless".

The manner in which cleaning work is acquired is also fascinating. Most of the women I spoke to were able to find private cleaning work through connections, i.e. family and friends. Similarly, Shakira hinted at the fact that becoming a government cleaner (the goal of most of these women), is only possible if one knows the right people or has the right people vouching for you. These dynamics are especially interesting in a context where social capital appears to be increasingly important for survival. What these potential research areas

reiterate is the fact that private company cleaning workers in the hospital are located at a unique intersection conditions.

A Final Thought

Grossman (2011: 35) makes an important observation. He speaks to the fact that a lot of research (qualitative in particular) proposes to give a voice to those who are marginalised or voiceless. What he notes as the actual problem is silencing: “we are not dealing with the problem of silence, but rather with the problem of silencing; not with the problem of those who appear silent, but those who impose silencing, who will not or cannot hear, and choose not to listen.” Through the interviews I have conducted and Shakira’s experience described at the beginning of this chapter, it is apparent that these cleaners have a voice, can articulate their concerns and frustrations and can see how they are undervalued. The hard work lies in getting their voices heard by those who impose their conditions and who knowingly and unknowingly perpetuate them.

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Appendix A: Participant Information Sheet



**University of Cape Town
Department of Sociology**

Participant Information Sheet The experiences of hospital cleaning staff

Dear Madam,

My name is Lyndsey Petro. I am a student at the University of Cape Town. For my degree, I have to complete a research project. For my research project this year, I am interested in looking at the everyday work experiences of non-medical hospital staff and cleaning staff in particular. Through this research project I hope to get a realistic picture of the experiences of these workers and how they feel about their job in the hospital.

I am asking you to help me learn more about the experiences of cleaners in the hospital through your personal story. I would like to talk to you about your experiences and feelings about your job so that I can begin to answer my research question. This would involve meeting you and asking you about your experiences. This would take about one hour. I may ask to speak to you again. Please note:

- Your name will not be used in any part of the project.
- This letter is only a request. Taking part in this project is voluntary; you can choose to or not. If you choose to participate and then wish to leave the project at any stage, or not answer any question, I will respect your choice.
- If I want to include anything you say in my final project, I will ask for your permission first.
- This research project is not connected to the hospital or any other company. Your participation and responses will not be shared with your employer.
- My project will be read by my supervisor, examiners and will be put in the University's library.
- This project is for academic purposes only. Unfortunately, I will not be able to help you with any problems you may have at work or at home.

If you have any questions, please feel free to contact me on 084 569 4526. I hope that you will consider helping me with my project. It will be greatly appreciated.

Sincerely,
Lyndsey Petro

Appendix B: Participant Profiles

Brief profiles of the participants in my study:

Crystal:

Crystal is 27 years old. She grew up in Manenberg and attended Manenberg High School where she completed her Matric. She is married with two young children. For now, in order to get help with her newborn, she lives with her mother in Blackheath. Crystal worked as a cashier at Pick 'n Pay before. After her first son was born Crystal was at home for two years. She was looking for work and got the number for the cleaning company she now works for.

Crystal works for a private cleaning company as a General Assistant on a permanent contract. She has been working for the company for a year and a half. Her shifts are from 7:00am to 16:00pm from Monday to Friday. She now works mainly in the doctor's offices and cleans toilets and showers. If necessary she "helps out by other wards". She works at a regional hospital.

Dawn:

Dawn is 32 years old. She is a single mother of two. Her children are four and one years old. She is currently completing her Matric through the Department of Education who have set up special classes at the hospital she works at. Before she began working as a cleaner, she used to work at Pick 'n Pay. She has worked as a cleaner for two private companies. The first she worked with for a year and she is in her fourth year with her current employer. She has worked at the same government hospital for the past five years, but with the two different companies.

Dawn is a General Assistant. She has a permanent contract. She became permanent after a compulsory three-month probation period. She works Monday to Friday from 7:00am to 16:00pm. While she currently works mostly in the offices of the hospital, she has also worked in Admissions, the Nursery and Labour Ward. Her hospital is a regional one.

Glenda:

Glenda is 42 years old. She is originally from Zimbabwe, but has been in South Africa since 2007. She is married with five children between the ages of five and 22. She also takes care of another child that is five months old. Glenda went to school in Zimbabwe and received her O-level (Ordinary Level) qualification there. When she first arrived in South Africa she did piece-meal jobs cleaning people's homes. She lives in Phillipi with her husband, two of her children and the baby she cares for. Now she works for a private cleaning company.

Glenda has worked as a cleaner with a private company for two years. A friend of hers was working for the company and gave her name to the "person who was employing people". Glenda describes her contract as permanent. She goes to

renew her contract every six months. She works mainly in the medical wards of a government hospital, and is usually allocated to the wards when people, “are not present”. Her workweek ‘rotates’ as she works for five days one week and two days the next. Her workday starts at 7:00am and ends at 19:00pm. She works at a tertiary hospital.

Joyce:

Joyce is 41 years old. While she was born in Oudtshoorn, she grew up in Mitchell’s Plain; “It’s my hometown”. She is married with no children. Her and her husband live in Delft. She attended Mondale High School. Having left school after failing Grade 10, Joyce is now working on completing her Matric. She used to work as a casual on flexi-time at Shoprite, but was at home for a few years before she started working as a cleaner. Her mother heard about this private cleaning company and suggested Joyce look into it.

For the past five to six years Joyce has worked, “Unfortunately for a private company”. She is a permanent General Worker. Her hours are from 7:00am to 16:00pm, Monday to Friday. She is the sole cleaner working in the Out Patient’s Department (OPD) at her regional government hospital. She also works in the Orthopedics Ward.

Marion:

Marion is 34 years old. She is not married, but lives with her partner in Delft. She has one child who is 13 years old. Marion went to Kleinvele High School in Eersterivier. There she completed Grade 8. She used to work in Cape Town, but the place she worked at closed down. Her sister found her her current job.

Marion is now a General Cleaner for a private cleaning company. She has worked as a cleaner for the past two years and became permanent in August 2012. She has worked at four different government hospitals and has been at the current one for the past few months. Marion works from 7:00am to 16:00pm, Monday to Friday. She works on the Ground Floor of the hospital covering “a long passage” so she is in contact with lots of different patients. Mostly, however, she works in wards with children in them. She works at Karl Bremer, a district hospital.

Shakira:

Shakira is 22 years old. She is single and lives with her mother in Delft. She completed her Grade 10 at Rosendal High School in Delft. Before becoming a cleaner she worked in a deli doing stocktaking and with disabled children at Alta Du Toit School in Kuils River. After being at home for three months looking for work she got in touch with a friend of her boyfriend’s uncle. Through this connection she got in touch with the assistant of the owner of the private cleaning company she now works for.

Shakira has now worked as a General Worker for this company for two years. She has a permanent contract which she needs to renew every two to three

months. She works for 15 days each month, and from 7:00am to 18:00pm each day. Her job means that she works all over her regional hospital: "First Floor, Second Floor, Third Floor, Fifth Floor, Sixth Floor..." including Labour Ward and Children's Wards.

Stacey:

Stacey is 23 years old. She grew up in Touwsrivier, but now stays in Kraaifontein. She attended De Kruine Secondary School, but dropped out after falling pregnant in Grade 8 or 10. Stacey has one child who is three years old. Before working as a private cleaner in a hospital, Stacey worked at a Fruit and Veg City in Durbanville as a general kitchen worker and as a packer at the front of the shop. After being unemployed for two months, her uncle suggested she work as a private company cleaner.

For the past year and a half Stacey has worked as a private company cleaner at a government hospital. She works seven days a week from 8:00am to 16:00pm, with every second weekend off. Her time at work is spent cleaning offices and hallways. Stacey works at a tertiary hospital.

Susan:

Susan is 38 years old. She is single and has no children. She attended Central Park Primary School in Bonteheuwel and left school after Grade 8. She lives with her mother in Bonteheuwel. Her previous jobs have included babysitting, helping out at a crèche and working in a bakery.

Susan has worked for her private cleaning company for four years. She "started off as a cleaner and after that...became a supervisor". After working at the hospital for a year she was approached to become a supervisor. The previous supervisor could no longer work as she had family matters to attend to. She has a permanent contract. Susan works the nightshift from 19:00pm to 7:00am. As there is currently no replacement for her, she works every day of the week. She would usually get two days off. Her work means she is in all the wards of her tertiary hospital.